CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-19 Demonstrations	Centers for Medicare & Medicaid Services (CMS)
Transmittal 169	**Date: February 17, 2017**
	Change Request 9916

Transmittal 169, dated February 17, 2017 is rescinded and will be replaced at a later date.

SUBJECT: Episode Payment Model Operations

I. SUMMARY OF CHANGES: Section 1115A of the Social Security Act authorizes the Centers for Medicare and Medicaid Services (CMS) to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries. CMS has previously used its legislative authority to create payment models, such as the Bundled Payments for Care Improvement (BPCI) initiative, to test bundled payments. In April 2016, CMS began testing a new bundled payment model called the Comprehensive Care for Joint Replacement (CJR) Model. The CJR Model requires that hospitals test bundled payments for lower extremity joint replacement (LEJR) episodes in multiple geographic areas. The CJR Model is designed to promote quality and financial accountability for episodes of care surrounding a LEJR and test whether bundled payments to acute care hospitals for LEJR episodes of care can reduce Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries.

In December 2016, CMS issued a final rule that implements an additional set of models that share many design features of the CJR Model, but focus on three different clinical conditions. The new Episode Payment Models (EPMs) will focus on acute myocardial infarction (AMI), coronary artery bypass graft (CABG), and surgical hip and femur fracture treatment (SHFFT), most frequently hip pinning. These models will begin in 2017 and run for 5 performance years (PY).

EFFECTIVE DATE: July 1, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 3, 2017

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: 169	Date: February 17, 2017	Change Request: 9916

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SUBJECT: Episode Payment Model Operations

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I. GENERAL INFORMATION

A. Background: Section 1115A of the Social Security Act authorizes the Centers for Medicare and Medicaid Services (CMS) to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries. CMS has previously used its legislative authority to create payment models, such as the Bundled Payments for Care Improvement (BPCI) initiative, to test bundled payments. In April 2016, CMS began testing a new bundled payment model called the Comprehensive Care for Joint Replacement (CJR) Model. The CJR Model requires that hospitals test bundled payments for lower extremity joint replacement (LEJR) episodes in multiple geographic areas. The CJR Model is designed to promote quality and financial accountability for episodes of care surrounding a LEJR and test whether bundled payments to acute care hospitals for LEJR episodes of care can reduce Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries.

In December 2016, CMS issued a final rule that implements an additional set of models that share many design features of the CJR Model, but focus on three different clinical conditions. The new Episode Payment Models (EPMs) will focus on acute myocardial infarction (AMI), coronary artery bypass graft (CABG), and surgical hip and femur fracture treatment (SHFFT), most frequently hip pinning. These models will begin in 2017 and run for 5 performance years (PY).

PY1: July 1, 2017 – December 31, 2017

PY2: January 1, 2018 - December 31, 2018

PY3: January 1, 2019 - December 31, 2019

PY4: January 1, 2020 - December 31, 2020

PY5: January 1, 2021 - December 31, 2021

Under the EPMs, acute care hospitals in certain selected geographic areas will take on quality and payment accountability for retrospectively calculated bundled payments for AMI, CABG, and/or SHFFT episodes. All related care within 90 days of hospital discharge will be included in the episode of care.

The final rule also finalized the concurrent implementation of a Cardiac Rehabilitation Incentive Payment (CR) Model. The CR Incentive Payment Model will provide incentive payments to hospitals that discharge patients following an AMI or CABG with referral to cardiac rehabilitation/intensive cardiac rehabilitation, an underutilized but effective treatment for patients recovering from an acute cardiac event. Incentive payments will be tied to the number of cardiac rehabilitation/intensive cardiac rehabilitation visits that the patient completes. The CR Incentive Payment Model will be implemented in two separate cohorts in order to test its efficacy, one in the same regions as the AMI and CABG models, and one in purely fee-for-service

FFS regions. No systems changes are required for this CR Incentive Payment Model in this Change Request.

EPM Episodes of Care

AMI, CABG, and SHFFT procedures are currently paid under the Inpatient Prospective Payment System (IPPS) through Medicare Severity Diagnosis Related Groups (MS-DRGs). Under the EPMs, episodes would begin with admission to an acute care hospital when a claim is assigned to an MS-DRG included in one of the EPMs upon beneficiary discharge and paid under the IPPS, and would end 90 days after the date of discharge from the acute care hospital. The episode would include the inpatient procedure, inpatient stay, and all related care as defined under the model that is covered under Medicare Parts A and B within the 90 days after discharge, including hospital care, post-acute care, and physician services.

EPM Participants

Participants will be acute care hospitals, who will be the episode initiators (that is, the entities where the episodes begin) and will bear quality and episode payment accountability under the EPMs. CMS will require all hospitals paid under the IPPS and located in selected geographic areas to participate in the EPMs, with limited exceptions for some hospitals, such as those currently participating in BPCI Model 2 or 4 for the same clinical episodes. The care for eligible beneficiaries who receive care at these hospitals will automatically be included in the model.

EPM Model Beneficiary Inclusion Criteria

The defined population of Medicare beneficiaries whose care will be included in the EPMs must meet the following criteria upon admission to the anchor hospitalization:

• The beneficiary is enrolled in Medicare Part A and Part B throughout the duration of the episode.

• Not prospectively assigned to an ACO in the Next Generation ACO model, an ACO in a track of the Comprehensive ESRD Care Model incorporating downside risk for financial losses, or a Shared Savings Program ACO in Track 3.

• The beneficiary's eligibility for Medicare is not on the basis of the End Stage Renal Disease benefit.

• The beneficiary is not enrolled in any managed care plan.

• The beneficiary is not covered under a United Mine Workers of America health plan.

• Medicare is the primary payer.

EPM Episode Reconciliation Activities

CMS will continue paying hospitals and other providers according to the conventional Medicare FFS rules during all PYs. After each PY, the Medicare payments for services included in the episode for an EPM

beneficiary will be aggregated to calculate an actual episode payment. The actual episode payment will then be compared against an established EPM target price that reflects a discount over expected episode spending based on a blend of hospital-specific and regional historical episode data. Based on this comparison, and taking into consideration episode quality performance based on the composite quality score calculated for each hospital each performance year, CMS will determine whether reconciliation payment to (applicable for PYs 1-5) or recoupment from (applicable for some hospitals PYs 3-5 and other hospitals PYs 2-5) the hospital will be conducted. In addition, in order to be eligible for a reconciliation payment, the hospital must meet the applicable minimum composite quality score. Calculation of these reconciliation or recoupment amounts will be conducted by a specialty contractor annually beginning in 2018.

Identifying EPM Claims

To validate the retroactive identification of EPM episodes, CMS is associating the Demonstration Code 79 with the EPM initiative.

This code will be utilized to operationalize the waiver of the three-day stay requirement for covered Skilled Nursing Facility (SNF) services. This waiver will be effective in conjunction with the introduction of downside risk to the AMI episodes ending on or after January 1, 2019 (and beginning on or after 10/4/2018) and it will allow for the payment of SNF Claims for beneficiaries who have not met the three-day hospital stay requirement for claims containing the Demonstration code 79.

Skilled Nursing Facility Three-Day Waiver

In order to provide more comprehensive care across the post-acute spectrum and support the ability of participant hospitals to coordinate the care of beneficiaries, CMS will conditionally waive the three-day stay requirement for beneficiaries for covered Skilled Nursing Facility (SNF) services in AMI EPM episodes, effective with AMI EPM episodes that start on or after payment year 3 of the model (i.e. January 1, 2019).

Under Medicare rules, in order for Medicare to pay for SNF services, a beneficiary must have a qualifying hospital stay of at least 3 consecutive days (counting the day of hospital admission but not the day of discharge). Additional information regarding the skilled nursing facility benefit is available in the Medicare Benefit Manual (Pub 100–02), Chapter 8, "Skilled Nursing Facility Services."

B. Policy: This CR is intended to prepare our systems for implementation of the EPM models.

First, it establishes new model numbers and directs CMS contractors to associate specific model numbers to specific hospitals on the provider file and add demo codes to claims for eligible discharges.

Second, it directs CMS contractors to conduct beneficiary eligibility checks, including overall eligibility for the models as well as beneficiary service checks for additional related services such as post-discharge home visits.

Third, under EPM, CMS will allow a beneficiary in certain EPM AMI episodes to receive SNF services without having to meet the three-day requirement in performance years 3 through 5 of the model. This will allow payment of claims for SNF services delivered to beneficiaries at eligible sites.

As of October 4, 2018, it allows for payment of SNF claims without a 3-day hospital stay when the conditions below are met. CMS will waive the 3-day hospital stay requirement, subject to all of the

following conditions:

• The hospitalization does not meet the prerequisite hospital stay of at least 3 consecutive days for Part A coverage of ‘‘extended care’’ services in a SNF. If the hospital stay would lead to covered SNF services in the absence of the waiver, then the waiver is not necessary for the stay.

• The discharge is from a hospital participating in an EPM. Participants can be confirmed by a posted file on the CMS website and will be shared with contractors on a recurring basis as needed and no less frequently than quarterly.

• The beneficiary must have been discharged from the EPM hospital for one of the specified MS–DRGs (231-236, 246-251, 280-282) within 30 days prior to the initiation of SNF services. We note that this list of MS-DRGs may need to be updated prior to October 4, 2018 if annual changes to the IPPS MS-DRGs add, combine or delete any of these DRGs.

• The beneficiary meets the criteria for inclusion in an EPM at the time of SNF admission: That is, he or she is enrolled in Part A and Part B, eligibility is not on the basis of ESRD, is not enrolled in any managed care plan, is not covered under a United Mine Workers of American health plan, is not prospectively assigned to an ACO in the Next Generation ACO model, an ACO in a track of the Comprehensive ESRD Care Model incorporating downside risk for financial losses, or a Shared Savings Program ACO in Track 3, and Medicare is the primary payer.

• The waiver will apply if the SNF is qualified to admit EPM beneficiaries under the waiver. A list of qualified SNFs will be communicated to Medicare Administrative Contractors and CMS Shared Systems Maintainers via a quarterly list, developed by CMS and posted to the CMS website on a quarterly basis. The list will contain those SNFs with an overall star rating of three stars or better, consistent with the final rule policy, for at least 7 of the preceding 12 months of the rolling data used to create the quarterly list.

• The SNF must include Demonstration Code 79 in the Treatment Authorization field on claims that qualify for the SNF waiver under the EPM. Note: The waiver is not valid for swing bed (TOB 18X) stays.

• Other requirements. All other Medicare rules for coverage and payment of Part A-covered SNF services continue to apply.

Post-Discharge Home Visits

In order for Medicare to pay for home health services, a beneficiary must be determined to be “homebound” and in need of skilled care (skilled nursing, physical therapy or speech-language pathology services). Additional information regarding the home health benefit is available in the Medicare Benefit Manual (Pub 100–02), Chapter 7, '"Home Health Services."

Medicare policy allows physicians and nonphysician practitioners (NPPs) to furnish and bill for visits to any beneficiary’s home or place of residence under the physician fee schedule (PFS). Medicare policy also allows licensed clinical staff to furnish services “incident to” the physician or NPP visit at a beneficiary’s home when such services are provided under the direct supervision of the physician or NPP. Licensed clinical staff may be any employees, leased employees, or independent contractors who are licensed under applicable state law to perform ordered services. Additional information regarding the “incident to”

requirements is available in the Medicare Benefit Manual (Pub 100–02), Chapter 15, Covered Medical and Other Health Services, Sections 60-60.4.1.

For those EPM beneficiaries who could benefit from home visits by licensed clinical staff for purposes of assessment and monitoring of their clinical condition, care coordination, and improving adherence with treatment but who are not homebound or otherwise eligible for the Medicare home health benefit, CMS will waive the "incident to" direct physician supervision requirement to allow a beneficiary who does not qualify for Medicare home health services to receive post-discharge visits in his or her home or place of residence anytime during the episode, subject to the following conditions:

- Licensed clinical staff will furnish the service under the general supervision of a physician or nonphysicianpractitioner, who may be either an employee or a contractor of the participant hospital.

- Services will be billed under the PFS by the supervising physician or NPP or by the hospital to which the supervising physician has reassigned his or her billing rights.Up to 9 post discharge home visits can be billed and paid per beneficiary during each 90-day post-anchor hospitalization EPM episode.

- The service will be billed with HCPCS G-code 9863, which is specific to the AMI, CABG, or SHFFT model home visits for patient assessment. These visits must be performed by clinical staff for an individual not considered homebound, and may include but not necessarily be limited to patient assessment of clinical status, safety/fall prevention, functional status/ambulation, medication reconciliation/management, compliance with orders/plan of care, performance of activities of daily living, and ensuring beneficiary connections to community and other services. The HCPCS G-code is approved for use only in the Medicare approved AMI, CABG, or SHFFT models and may not be billed for a 30-day period covered by a transitional care management code and paid under the PFS.

- The service cannot be furnished to an EPM beneficiary who has qualified, or would qualify, for home health services when the visit was furnished.

As described in the Medicare Claims Processing Manual (Pub 100-04), Chapter 12, Sections 40-40.4, Medicare policy generally does not allow for separate billing and payment for a postoperative visit furnished during the global period of a surgery when it is related to recovery from the surgery. However, for the EPMs, CMS will allow the surgeon or other practitioners to bill and be paid separately for a post-discharge home visit that was furnished in accordance with these conditions.

CMS expects that the post-discharge home visits by licensed clinical staff could include patient assessment, monitoring, assessment of functional status and fall risk, review of medications, assessment of adherence with treatment recommendations, patient education, communication and coordination with other treating clinicians, and care management to improve beneficiary connections to community and other services.

Additional information on billing and payment for the post-discharge home visit HCPCS G-Code will be available in the July 2017 release of the Medicare Physician Fee Schedule (MPFS) Recurring Update.

Billing and Payment for Telehealth Services

Medicare policy covers and pays for telehealth services when beneficiaries are located in specific geographic areas. Within those geographic areas, beneficiaries must be located in one of the health care settings that are specified in the statute as eligible originating sites. The service 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. Additional information regarding Medicare telehealth services is available in the Medicare Benefit Policy Manual (Pub 100-02), chapter 15, section 270 and the Medicare Claims Processing Manual (Pub 100-04), chapter 12, section 190.

Under EPM, CMS will allow a beneficiary in an EPM episode in any geographic area to receive services via telehealth. CMS also will allow a home or place of residence to be an originating site for beneficiaries in an EPM episode. This will allow payment of claims for telehealth services delivered to beneficiaries at eligible originating sites or at their residence, regardless of the geographic location of the beneficiary. CMS will waive these telehealth requirements, subject to the following conditions:

- Telehealth services cannot substitute for 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 the EPM model.

- The telehealth geographic area waiver and the allowance of home as an originating site under the EPM model does not apply for instances where a physician or allowed NPP is performing a face-to-face encounter for the purposes of certifying patient eligibility for the Medicare home health benefit.

- The principal diagnosis code reported on the telehealth claim cannot be one that is specifically excluded from the proposed EPM episode definition.

- 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 is furnishing an evaluation and management visit via telehealth to a beneficiary at home, the visit must be billed by one of nine unique HCPCS G-codes developed for the EPM model that reflect the home setting.

- For level 4 and 5 EPM telehealth home visits, the physician must document in the medical record that auxiliary licensed clinical staff were available on site in the patient's home during the visit or document the reason that such a high-level visit would not require such personnel.

- Physicians billing distant site telehealth services under these waivers must include the GT modifier on the claim, which attests that the service was furnished in accordance with all relevant coverage and payment requirements.

- The facility fee paid by Medicare to an originating site for a telehealth service would be waived if the service was originated in the beneficiary's home.

Additional information on billing and payment for the telehealth home visit HCPCS G-Codes will be available in the July 2017 release of the MPFS Recurring Update.

Cardiac Rehabilitation (CR) Incentive Payment Model Billing and Payment

Cardiac Rehabilitation services are covered by Medicare and have been shown by research to improve health outcomes. However these cardiac rehabilitation services have been historically under-utilized by Medicare beneficiaries. The CR Incentive Payment model is designed to provide participant hospitals in 90 different MSAs with incentive payments to encourage the use of cardiac rehabilitation services for beneficiaries in certain MS-DRGs. Providers and suppliers will continue to be paid under the usual Medicare payment system rules and procedures. Following the end of a model performance year, depending on beneficiaries' utilization of CR/Intensive CR services, participant hospitals may receive an additional incentive payment from Medicare. We have provided a waiver of the definition of a physician to include a physician or non-physician practitioner (defined for the purposes of this waiver as a physician assistant, nurse practitioner, or clinical nurse specialist) in performing specific physician functions in conjunction with the delivery of cardiac rehabilitation services to EPM-CR and FFS-CR beneficiaries during AMI care periods and CABG care periods.

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	
9916.1	Contractors shall allow a new model indicator of '6' in the "Demonstration Model Participation" (DMP) fields, in addition to the current values.					X				
9916.1.1	Contractors shall ensure the new effective/termination date fields can be modified by A/B MACs (A).	X				X				
9916.1.2	Contractors shall add one occurrence of effective/termination dates for Model indicator '6,'and populate the dates with 07/01/17 – 12/31/21.					X				
9916.2	CMS shall provide contractors with a list containing Medicare identification numbers (legacy) of Inpatient Prospective Payment System (IPPS) hospitals participating in the episode payment models (EPM), as well as the effective date of participation.									CMS
9916.2.1	CMS shall provide updates to the list of hospitals participating in the EPMs on a quarterly basis via Technical Direction Letter(s). Note: Quarterly update files will be full replacement files.									CMS
9916.3	Contractors shall create a one-time utility to populate the DMP field on the inpatient provider file with a '6,' for IPPS hospitals participating in the EPMs respectively based on the list provided by CMS per requirement 9916.2.1.					X				
9916.3.1	Contractors shall make the necessary updates to the provider file upon receipt of updated EPM participating hospital lists provided by CMS per requirement 2.1.	X								
9916.3.1.1	Contractors shall <u>not</u> populate the DMP field on the provider file with a '6,' if a value (other than blank) is already present in one or more of the DMP fields, unless the termination date (if present) of all other value(s) is prior to the effective date of participation in the AMI, CABG, and SHFFT models.	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Note: When a value of '2' or '4' is present in any of the DMP fields, this action only applies to DRGs 231, 232, 233, 234, 235, 236, 246, 247, 248, 249, 250, 251, 280, 281, 282									
9916.3.1.1.1	When executing the one-time utility per requirement 3, contractors shall, for all participants, set the effective date of participation in the EPMs as July 1, 2017 and the termination date as December 31, 2021, unless otherwise instructed by CMS.					X				
9916.3.1.1.1.1	When updating the provider file per requirement 3.1, contractors shall set the effective date of participation in the AMI, CABG, and SHFFT models as the date specified by CMS and the termination date as December 31, 2021.	X								
9916.4	For incoming IPPS hospital claims submitted by participating hospitals in the AMI EPM (as identified by the presence of a '6' in the DMP field), FISS shall determine if the DRG assigned on the claim is: (DMP=6) DRGs 231, 232, 233, 234, 235, 236, 246, 247, 248, 249, 250, 251, 280, 281, 282					X				
9916.5	If the criteria in requirement 4 are met, FISS shall set EPM demo code 79 in the demonstration code field at the header level of the IPPS hospital claim and pass the demo code to CWF.					X			X	
9916.5.1	FISS shall <u>not</u> set demonstration code '79' if the DRG on the IPPS hospital claim is other than 231, 232, 233, 234, 235, 236, 246, 247, 248, 249, 250, 251, 280, 281, or 282					X				
9916.5.1.1	FISS shall not set demonstration code '79' if the incoming claim is a Medicare Secondary Payer (MSP) claim.					X				
9916.5.1.1.1	Contractors shall allow EPM demo code '79', if present in the Demonstration code field at the claim header level, to flow to the downstream systems.								X	FPS, IDR, MedPar, NCH, PS&R
9916.6	Effective for claims received on and after July 1, 2017, CWF shall reject an incoming IPPS hospital claim containing demonstration code '79' and with an								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	admit date on or after July 1, 2017, if any of the following is true as of the date of admission: • The beneficiary does not have both Part A and Part B eligibility; • The beneficiary is in a managed care plan; • The beneficiary qualifies for Medicare through the End Stage Renal Disease (ESRD) benefit; • The beneficiary is covered under a United Mine Workers of America health plan; or • Medicare is not the primary payer									
9916.6.1	FISS shall accept the new CWF reject and remove demonstration code '79' from the incoming IPPS hospital claim.					X				
9916.7	Contractors shall be advised of new HCPCS codes for EPMs post discharge home visits and telehealth services on a MPFS quarterly basis.		X							
9916.8	Contractors shall allow EPMs post discharge home visit claims for licensed clinicians only when the claim contains the following HCPCS code: G9863 TOS 1		X							
9916.9	Contractors shall allow no more than 52 post discharge home visits for G9863 (TOS 1) within a year.								X	
9916.9.1	Contractors shall deny post discharge home visits that exceed 52 visits within a year.		X							
9916.10	For professional claims, contractors shall return as unprocessable claims that exceed the maximum limit of 52 post discharge home visits within a year. Contractors shall use the following messages: • Claims Adjustment Reason Code (CARC): 119 - "Benefit maximum for this time period		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	or occurrence has been reached.," and • Remittance Advice Remark Code (RARC): N362- "The number of Days or Units of service exceeds our acceptable maximum." • Group Code: CO (Contractual Obligation)									
9916.11	Upon receipt of a SNF claim with demonstration code '79' in the Treatment Authorization Code field and occurrence span code 70 with less than three (3) days reported in the span, FISS shall compare the effective date(s) on the SNF DWP field to the date of admission to the SNF.					X				
9916.11.1	If the date of admission to the SNF is within the billing provider's effective date(s) as a qualified SNF, FISS shall set EPM demonstration code '79' in the demonstration code field at the header level of the SNF claim and pass the demo code to CWF.					X				
9916.12	If the date of admission to the SNF is outside the SNF effective date(s) of eligibility for the waiver, i.e. on or after 10/4/2018 and prior to 12/31/2021, FISS shall <u>not</u> set demonstration code '79' at the header level of the SNF claim and shall apply qualifying stay edits as usual.					X				
9916.13	FISS shall bypass qualifying stay edits for incoming SNF claims that meet the following requirements: • Demonstration code '79' is present in the demo code field at the claim header level; Occurrence span code '70' is present with at least one (1) day reported in the span.					X				
9916.14	Upon receipt of an incoming SNF claim where demonstration code '79' is present in the demo code field, CWF shall bypass the qualifying stay edits and allow the incoming SNF claim if there is a paid IPPS hospital claim in history that meets all of the following								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	SNF waiver criteria: • The hospital discharge date equal to or within 30 days prior to the admission date on the incoming SNF claim; • Demonstration code '79' is present on the IPPS hospital claim in history; • Incoming SNF claim (demo 79) has occurrence span code 70 with less than 3 days indicated in the span. Note: The SNF waiver does not apply to TOB 18X.									
9916.14.1	FISS shall accept the CWF reject and remove demonstration code '79' from the demo code field on the incoming SNF claim.					X				
9916.15	For SNF claims that do not meet the SNF waiver criteria in this change request, contractors shall apply the qualifying stay edits as usual.					X			X	
9916.16	Contractors shall note that for the purpose of this CR, "date of admission to the SNF" refers to the date the beneficiary began the SNF stay, not the FROM date of service on the claim. If the SNF has a DWP occurrence that is effective as of the date of admission (i.e., the date the beneficiary entered the SNF), then the SNF waiver shall be applied to the entire stay – even if the SNF loses its 3-star quality rating during the course of the stay.	X				X				STC
9916.17	Contractors shall create and assign a reason code to indicate that the bill type and demonstration code are incompatible and will assign this reason code when a TOB other than 21X is received with '79' in the "Treatment Authorization Code field."					X				
9916.17.1	Upon receipt of the FISS reason code, contractors shall RTP the SNF claim so that the provider may remove Treatment Authorization Code '79'.	X								
9916.18	Contractors shall be available for a one-hour conference call with CMS on a date prior to October					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	4, 2018 to discuss testing issues for the SNF DWP file.									
9916.18.1	Upon receipt of the FISS reason code, contractors shall RTP the SNF claim so that the provider may remove Treatment Authorization Code ‘79’.	X								
9916.19	Contractors shall assign reason code to SNF claims received with ‘79’ in the Treatment Authorization Code field and an occurrence span code ‘70’ with 3 or more days reported in the span.					X				
9916.19.1	Upon receipt of the FISS reason code, contractors shall RTP the SNF claim so that the provider may remove Treatment Authorization Code ‘79’ or correct the occurrence code and/or span.	X								
9916.20	Contractors shall be available for a one-hour conference call with CMS on a date prior to July 2017, to discuss testing issues for the SNF DWP file.	X	X			X				CMS, STC, VDCs

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9916.21	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X			

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:

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

V. CONTACTS

Pre-Implementation Contact(s): Leanne Clark, 410-786-0657 or leanne.clark@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: 0

79 FR 67584). We do not believe that the AMI, CABG, and SHFFT post-discharge home visits, which can include nursing assessments for chronic conditions for which care may be affected by the surgery, would replace or substantially duplicate the kind of post-operative visits involved in furnishing post-operative follow-up care for the global surgery procedure under the PFS. Instead, we anticipate that the work of these post-discharge visits will be similar to the work furnished by the physician coordinating the patient's overall episode care. Therefore, we proposed to waive the global surgery billing rules to allow the surgeon or other practitioners to furnish and bill for the post-discharge home visits during surgical global periods.

Comment: Several commenters supported the proposal to waive current Medicare billing rules for global surgeries to allow the separate billing of these post-discharge home visits by the physician or nonphysician practitioner who performed the EPM procedure.

One commenter supported the proposal, but urged CMS to clarify how this policy will interact with the PFS proposal for CY 2017 to require billing HCPCS G-codes during the global period to collect information on post-surgical visits.

Response: We appreciate the support on these issues. In response to the request for clarification, we note that since the post-discharge home visits furnished to EPM beneficiaries are being paid for, they do not need to be separately reported under the global surgery data collection requirements under the PFS. (See the CY 2017 PFS Final Rule, 81 FR 80170, for the finalized policies related to the global surgery data collection requirements under the PFS.)

Final Decision: Services furnished under the waiver will be billed under the PFS by the physician or nonphysician practitioner or by the entity, including a hospital, to which the supervising physician or nonphysician practitioner has reassigned his or her benefits. We are also waiving current Medicare billing rules in order to allow the separate reporting by the physician who performed a procedure during the anchor hospitalization of the EPM episode of these post-discharge home visits during surgical global periods when he or she is providing the general supervision of the post-discharge home visit.

The post-discharge home visit will be billed with the new HCPCS code G9863, displayed in Table 49. This code will be payable for EPM model beneficiaries beginning July 1, 2017, the start date of the first EPM performance year as discussed in section III.D.2. of this final rule. Rather than finalizing the specific RVUs for this new HCPCS code in this final rule, we are finalizing them through reference to the RVUs for another HCPCS G-code paid under the PFS. Specifically, the RVUs for this new code will be based upon the same inputs used to determine the payment rate for HCPCS code G9187 (BPCI initiative home visit for patient assessment performed by a qualified health care professional for individuals not considered homebound including, but not limited to, assessment of safety, falls, clinical status, fluid status, medication reconciliation/management, patient compliance with orders/plan of care, performance of activities of daily living, appropriateness of care setting; (for use only in the Medicare-approved BPCI initiative); may not be billed for a 30-day period covered by a transitional care management code), the specific HCPCS G-code currently used to report post-discharge home visits under BPCI. We are crosswalking the RVUs for new HCPCS code G9863 to the RVUs for the existing post-discharge home visit HCPCS G-code for the BPCI model because, given our view of the similarities between these two services in the two different models and the similar HCPCS G-code descriptors, we expect the resources required to be the same so the two codes are assigned the same inputs under the standard PFS ratesetting methodologies. In summary, we are finalizing the policy in this EPM final rule that the new HCPCS code G9863 for EPM post-discharge home visits will have the same RVUs as HCPCS code G9187 for BPCI model post-discharge home visits.

The CY 2017 RVUs, geographic practice cost indices and conversion factor that determine the PFS payment for HCPCS code G9187 are included in the CY 2017 PFS Final Rule. We will annually update the RVUs for HCPCS code G9863 for post-discharge home visits for EPM beneficiaries by crosswalking the RVUs for HCPCS code G9863 to HCPCS code G9187 as part of the annual PFS update, and information on the update will be included in the PFS Final Rule each year.

TABLE 49—HCPCS CODE FOR POST-DISCHARGE HOME VISITS FOR EPM BENEFICIARIES

HCPCS code number	Long descriptor	Short descriptor	RVUs equal to those of this HCPCS code for same calendar year under the PFS
G9863	Episode Payment Model (EPM)—AMI, CABG, or SHFFT model home visit for patient assessment performed by clinical staff for an individual not considered homebound, including, but not necessarily limited to patient assessment of clinical status, safety/fall prevention, functional status/ambulation, medication reconciliation/management, compliance with orders/plan of care, performance of activities of daily living, and ensuring beneficiary connections to community and other services; for use only in the Medicare approved EPM—AMI, CABG, or SHFFT model; may not be billed for a 30-day period covered by a transitional care management code.	EPM in home visit	G9187

The waiver of direct supervision requirements for certain post-discharge home visits is set forth at § 512.600. The waiver of certain post-operative billing restrictions under the PFS global surgery rules is set forth at § 512.615.

5. Billing and Payment for Telehealth Services

As discussed in the previous section, we expect that the EPMs' design features will lead to greater interest on

TABLE 50—HCPCS CODES FOR TELEHEALTH VISITS FOR EPM BENEFICIARIES IN HOME OR PLACE OF RESIDENCE

Code number	Long descriptor	Short descriptor	Work and MP RVUs equal to those of the corresponding office/outpatient E/M visit CPT code for same calendar year under the PFS
G9864	Remote in-home visit for the evaluation and management of a new patient for use only in the Medicare-approved Episode Payment Model—AMI, CABG, or SHFFT model, which requires these 3 key components: • A problem focused history; • A problem focused examination; and • Straightforward medical decision making, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.	In home E/M new pt 10 mins.	99201
G9865	Remote in-home visit for the evaluation and management of a new patient for use only in the Medicare-approved Episode Payment Model—AMI, CABG, or SHFFT model, which requires these 3 key components: • An expanded problem focused history; • An expanded problem focused examination; • Straightforward medical decision making, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.	In home E/M new pt 20 mins.	99202
G9866	Remote in-home visit for the evaluation and management of a new patient for use only in the Medicare-approved Episode Payment Model—AMI, CABG, or SHFFT model, which requires these 3 key components: • A detailed history; • A detailed examination; • Medical decision making of low complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.	In home E/M new pt 30 mins.	99203
G9867	Remote in-home visit for the evaluation and management of a new patient for use only in the Medicare-approved Episode Payment Model—AMI, CABG, or SHFFT model, which requires these 3 key components: • A comprehensive history; • A comprehensive examination; • Medical decision making of moderate complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.	In home E/M new pt 45 mins.	99204

TABLE 50—HCPCS CODES FOR TELEHEALTH VISITS FOR EPM BENEFICIARIES IN HOME OR PLACE OF RESIDENCE—Continued

Code number	Long descriptor	Short descriptor	Work and MP RVUs equal to those of the corresponding office/outpatient E/M visit CPT code for same calendar year under the PFS
G9868	Remote in-home visit for the evaluation and management of a new patient for use only in the Medicare-approved Episode Payment Model—AMI, CABG, or SHFFT model, which requires these 3 key components: • A comprehensive history; • A comprehensive examination; • Medical decision making of high complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.	In home E/M new pt 60 mins.	99205
G9869	Remote in-home visit for the evaluation and management of an established patient for use only in the Medicare-approved Episode Payment Model—AMI, CABG, or SHFFT model, which requires at least 2 of the following 3 key components: • A problem focused history; • A problem focused examination; • Straightforward medical decision making, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.	In home E/M est. pt 10 mins.	99212
G9870	Remote in-home visit for the evaluation and management of an established patient for use only in the Medicare-approved Episode Payment Model—AMI, CABG, or SHFFT model, which requires at least 2 of the following 3 key components: • An expanded problem focused history; • An expanded problem focused examination; • Medical decision making of low complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.	In home E/M est. pt 15 mins.	99213
G9871	Remote in-home visit for the evaluation and management of an established patient for use only in the Medicare-approved Episode Payment Model—AMI, CABG, or SHFFT model, which requires at least 2 of the following 3 key components: • A detailed history; • A detailed examination; • Medical decision making of moderate complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.	In home E/M est. pt 25 mins.	99214

TABLE 50—HCPCS CODES FOR TELEHEALTH VISITS FOR EPM BENEFICIARIES IN HOME OR PLACE OF RESIDENCE—Continued

Code number	Long descriptor	Short descriptor	Work and MP RVUs equal to those of the corresponding office/outpatient E/M visit CPT code for same calendar year under the PFS
G9872	Remote in-home visit for the evaluation and management of an established patient for use only in the Medicare-approved Episode Payment Model—AMI, CABG, or SHFFT model, which requires at least 2 of the following 3 key components: • A comprehensive history; • A comprehensive examination; • Medical decision making of high complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.	In home E/M est. pt 40 mins.	99215

6. SNF 3-Day Rule

a. Waiver of SNF 3-Day Rule

Pursuant to section 1861(i) of the Act, a beneficiary must have a prior inpatient hospital stays of no fewer than 3 consecutive days, within a short period of time (generally 30 days), in order to be eligible for Medicare coverage of inpatient SNF care. We refer to this as the SNF 3-day rule. We note that the SNF 3-day rule has been waived for Medicare SNF coverage under other episode payment models, including BPCI Model 2 and the CJR model. BPCI Model 2 awardees that request and are approved for the waiver can discharge Model 2 beneficiaries in fewer than 3 days from an anchor hospital stay to a SNF, where services are covered under Medicare Part A as long as all other coverage requirements for such services are satisfied. Under the CJR model, we adopted a waiver of the SNF 3-day rule that applies beginning in performance year 2 as hospitals are not bearing risk in their first year. As discussed in section V.N. of this final rule, we are revising the effective date of the waiver of the SNF 3-day rule for the CJR model, and we are stating that participant hospitals may begin using the waiver for episodes that begin on or after January 1, 2017.

We proposed EPM payment policies, similar to CJR payment policies which would require participating EPM hospitals to repay Medicare for excess episode spending beginning in performance year 2. Episode payment models like BPCI, CJR, and those being finalized in this final rule have the potential to mitigate the existing incentives under the Medicare program to overuse SNF benefits for beneficiaries, as well as to furnish many fragmented services that do not reflect significant coordinated attention to and management of complications following hospital discharge. The removal of these incentives in an EPM lays the groundwork for offering EPM participants greater flexibility around the parameters that determine SNF stay coverage. BPCI participants considering the early discharge of a beneficiary pursuant to the waiver during a Model 2 episode must evaluate whether early discharge to a SNF is clinically-appropriate and SNF services are medically-necessary. Next, they must balance that determination and the potential benefits to the hospital in the form of internal cost savings due to greater financial efficiency with the understanding that a subsequent hospital readmission, attributable to premature discharge or low quality SNF care, could substantially increase episode spending while also resulting in poorer quality of care for the beneficiary. Furthermore, early hospital discharge for a beneficiary who would otherwise not require a SNF stay (that is, the beneficiary has no identified skilled nursing or rehabilitation need that cannot be provided on an outpatient basis) following a hospital stay of typical length does not improve episode efficiency under episode-based payment models such as BPCI, the CJR model, or the EPMs in this final rule.

Because of the potential benefits we see for participating EPM hospitals, their provider partners, and beneficiaries, we proposed to waive in certain instances, where it is clinically-appropriate, the SNF 3-day rule for coverage of a SNF stay following the anchor hospitalization under EPM for episodes that begin on or after April 1, 2018. While our intent is to align the effective date of the availability of this program waiver with performance year 2 of the model, when repayment responsibility for actual episode spending that exceeds the target price begins, we believe that an effective date based on the start of the episode will be clearer to participant hospitals, SNFs, and others in determining whether the waiver is available for an EPM beneficiary. We believe that clarity regarding whether a waiver applies to SNF services furnished to a particular beneficiary is important to help ensure compliance with the conditions of the waiver and also improve our ability to monitor waivers for misuse. We proposed to use our authority under section 1115A of the Act with respect to certain SNFs that furnish Medicare Part A post-hospital extended care services to beneficiaries included in an EPM episode. We believe this waiver is necessary to the model test so that EPM participants can redesign care throughout the episode continuum of care extending to 90 days post-discharge from the anchor hospital stay in order to maximize quality and hospital financial efficiency, as well as reduce episode spending under Medicare. However, we did not propose to waive this requirement in performance year 1, when EPM participants are not responsible for excess actual episode spending. We believe that there is some potential for early hospital discharge