CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1240	**Date: May 21, 2013**
	Change Request 7887

NOTE: This Transmittal is no longer sensitive and is being re-communicated July 19, 2013. The Transmittal Number, date of Transmittal and all other information remain the same. This instruction may now be posted to the Internet.

SUBJECT: Affordable Care Act (ACA) Model 4 Bundled Payments for Care Improvement Episode of Care Implementation Phase Two

I. SUMMARY OF CHANGES: This change request represents the second and final phase of implementation of the Bundled Payments for Care Improvement initiative, Model 4. This pilot program is being run under the CMS Innovation Center"s model testing authority and is slated to be fully implemented in January 2013.

EFFECTIVE DATE: July 1, 2013
IMPLEMENTATION DATE: January 7, 2013; April 1, 2013 (A two release split will be needed to complete implementation)

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	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

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 obliged 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:
One-Time Notification
**Unless otherwise specified, the effective date is the date of service.*

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 1240	Date: May 21, 2013	Change Request: 7887

NOTE: This Transmittal is no longer sensitive and is being re-communicated July 19, 2013. The Transmittal Number, date of Transmittal and all other information remain the same. This instruction may now be posted to the Internet.

SUBJECT: Affordable Care Act (ACA) Model 4 Bundled Payments for Care Improvement – Episode of Care – Implementation Phase Two

Effective Date: July 1, 2013

Implementation Date: January 7, 2013 and April 1, 2013 (A two release split will be needed to complete implementation)

I. GENERAL INFORMATION

A. Background: The Affordable Care Act (ACA) provides a number of new tools and resources to help improve health care and lower costs for all Americans. Bundling payment for services that patients receive across a single episode of care, such as heart bypass surgery or a hip replacement, is one way to encourage doctors, hospitals and other health care providers to work together to better coordinate care for patients both when they are in the hospital and after they are discharged. Such initiatives can help improve health, improve the quality of care, and lower costs.

The Centers for Medicare and Medicaid Services (CMS) is working in partnership with providers to develop models of bundling payments through the Bundled Payments for Care Improvement initiative (BPCI). On August 23, 2011, CMS invited providers to apply to help test and develop four different models of bundling payments. In Model 4, the episode of care is defined as the acute care hospital stay and includes inpatient hospital services, Part B professional services furnished during the hospitalization, and hospital and Part B professional services for related readmissions. Applicants for this model will propose a target price for the episode that includes a single rate of discount off of expected payment (including both hospital and Part B professional services) for all beneficiaries with the agreed-upon Medicare Severity Diagnosis Related Group (MS-DRG). This model will require changes to payment starting in early 2013.

This implementation Change Request (CR) is the second in a multi-release series of change requests which together will implement the payment of claims for the Bundled Payments for Care Improvement Model 4. This CR continues the work that was begun with CR 7784 in October of 2012, and it will be followed by additional change requests to implement Medicare Summary Notice (MSN) changes, remittance advice and reporting requirements, which are currently slated for the April 2013 release.

B. Policy: Bundled Payments initiative Model 4 hospitals will receive a prospectively established bundled payment for agreed upon MS-DRGs. This will not apply to claims that are paid on a transfer per-diem basis. This payment will include both the DRG payment for the hospital and a fixed amount for the Part B physician services anticipated to be rendered during the admission. Separate payment for providers' professional services rendered during the inpatient hospital stay will not be made. Participating Model 4 Bundled Payments Initiative hospitals receiving payment will take responsibility for distributing payment to providers who would otherwise be paid separately for professional services under the physician fee schedule (PFS). Claims from physicians must be processed as no-pay claims if they occur between the inpatient hospital admission and discharge date in order to prevent duplicate payment of physicians under the bundled payment. Physicians' incentive payments will not be affected by participation in the Bundled Payments initiative.

Payment rates may be updated quarterly to allow for changes made to the PFS and Inpatient Prospective Payment System (IPPS). Indirect Medical Education (IME) and Disproportionate Share Hospital (DSH) payments to Model 4 hospitals will be calculated based on the non-discounted base DRG payment that would have been made in the absence of the model. Other applicable payment adjustors will also be calculated based on the base DRG that would otherwise have applied to the case, as opposed to the prospectively established amount paid through this initiative, which will be higher as it includes payment for Part B services as well as the base DRG payment. No separate outlier payments will be made. The regular Part A deductible and daily coinsurance amounts (when applicable) will continue to be applied to the claim. A fixed Part B copayment will be applied to the claim. The fixed Part B portion of the negotiated bundled payment will first be applied to the Part B deductible, if applicable. Additionally, the beneficiary will be responsible for paying a fixed Part B copayment, calculated as an approximation of what the Part B coinsurance would have been in the absence of this Model. Both the copayment and the deductible to be paid by the beneficiary for the Part B services must appear on the Medicare Summary Notice along with the Part A deductible and any applicable coinsurance.

Hospitals will not be paid for a readmission to the same hospital under this model unless the DRG is expressly excluded as unrelated. Unrelated readmissions will be defined by CMS, and a list of DRGs defining unrelated readmissions will be provided for each included MS-DRG. Physicians' services provided during a related readmission to the original treating hospital will not be paid separately. Related readmissions to a hospital other than the original treating hospital, as well as payments for physicians' services during related readmissions to hospitals other than the original treating hospital, will be reconciled retrospectively by a BPCI payment reconciliation contractor and payment recouped, as applicable.

Hospitals participating in this initiative must submit a Notice of Admission (NOA) when a beneficiary expected to be included in the model is admitted. This policy was included in CR 7784, issued as part of the October 2012 release. Hospitals will be paid a $500 payment upon submission of the NOA and will receive the balance of the prospectively established bundled payment when the hospital claim is processed. If the patient ultimately does not qualify for an episode payment based on a MS-DRG excluded from the Model 4 Bundled Payment Initiative, the $500.00 NOA payment will be recouped. Hospitals must submit the final claim within 60 days of the beneficiary's hospital admission or submit an interim claim during that time period to demonstrate that the beneficiary is still an inpatient. Otherwise, the beneficiary will be considered to be not subject to episode payment and the $500 will be recouped.

Payment of physician services included in the Model 4 Bundled Payments initiative will not affect eligibility for and calculation of incentive payments.

As part of performance monitoring and evaluation of this initiative, analyses of BPCI Model 4 claims shall be performed by contractors to CMS. A contractor also will monitor for unbundling by inappropriate shifting of Medicare services outside of the acute inpatient hospitalization.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7887.1	CMS shall provide FISS with a list of hospitals participating in the Model 4 BPCI, their Medicare identification numbers (legacy and NPI), the DRGs that shall be covered at that hospital, a list of unrelated DRGs, a contact person at each hospital, the prospectively established bundled payment for each select DRG and the portion of the payment designated as reimbursement for Part B services. This information may be updated quarterly.										CMS
7887.1.1	FISS shall establish recurring hours on the quarterly releases to receive file updates.						X				
7887.1.2	FISS shall update the provider file and Provider Demonstration file with the initial list of data supplied in BR 7887.1.						X				
7887.1.2.1	Contractors shall update the provider file and Provider demonstration file with quarterly updates as necessary.	X		X			X				
7887.2	All IPPS inpatient claims with an admission date on or after 01/01/13 shall be validated against the list of Model 4 hospitals and selected DRGs.						X				
7887.2.1	FISS shall apply the demo code 64 to the first demo code field on the claim record if all of the following are met: • Provider is enrolled in Model 4 BPCI • DRG on claim matches DRG on select list for that provider and move any additional demo codes present to the next available demo field(s).						X				
7887.2.1.1	FISS shall not allow the provider file to be updated with '4' for Veterans Administration (VA) and Indian Health Services (IHS) providers.						X				
7887.2.1.2	If more than one BPCI demo code is present, FISS shall move the corresponding demo number to the first Demonstration Number field on the transmit record to CWF in the following order: '64' – Model 4 '63' – Model 3 '62' – Model 2 '61' - Model 1						X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7887.2.1.3	If multiple demo codes are present in addition to BPCI demo codes, the BPCI demo code shall be placed in the first position in the hierarchy described in 7887.3.1.2.						X				
7887.2.2	If the claim is not from a Model 4 hospital and/or the DRG is not on the list of selected DRGs, FISS shall continue processing as Model 1, or under any existing demonstration rules, or under traditional for service (FFS) rules, whichever is applicable.						X				
7887.3	FISS shall return the NOA or claim to the provider if demonstration code '54' is present and demo code '64' is also present.						X				
7887.4	FISS shall return the Model 4 BPCI NOA to the provider when a matching NOA is found for demo 54. A match consists of the same beneficiary, provider and admission date.						X				
	BILLING REGULATIONS FOR HOSPITALS										
	Determination of Payment Rates										
7887.5	CMS shall negotiate Model 4 BPCI bundled payment rates to cover all Part A and Part B services for each DRG to be utilized at each Model 4 hospital.										CMS
7887.6	Contractors shall use the statement covers thru date for Model 4 claims, as is currently used for IPPS, in order to determine which version of Medicare Code Editor (MCE), GROUPER and PRICER shall be used to edit, group and price the claim.	X		X			X				
7887.7	Contractors shall continue to follow the current benefit rules for Model 4 claims when applying the Part A deductible, Part A coinsurance/lifetime daily rates and Part A blood deductible.	X		X			X			X	
7887.8	Contractors shall display the Part A deductible, coinsurance amounts and Part A blood deductible, if applicable, on the Medicare Summary Notice and Remittance Advice.	X		X			X				
7887.9	Contractors shall display the Part B demonstration payment for episode of care with Value code 'Y2' and send to CWF.	X		X			X				
7887.10	CWF shall apply the Part B demonstration payment displayed with Value code 'Y2' towards the unmet Part B deductible based on the year of the admission date and return trailer 07 with the amount applied to the Part B deductible and trailer 11 indicating the Part B year information.									X	

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7887.11	CMS shall petition the National Uniform Billing Committee (NUBC) for a new Value Code to represent the Part B Deductible.										CMS
7887.11.1	FISS shall store the Part B deductible amount returned from CWF with trailer 07 on the claim record and display it online using the new value code 'Y5".						X				
7887.12	Contractors shall display the Part B deductible amount and the Part B coinsurance amount on the Medicare Summary Notice.	X		X			X	1			
7887.13	FISS shall calculate the Part B copayment (coinsurance) as follows: (Part B demonstration amount [Y2] – Part B deductible applied [Y5])X 20%						X				
7887.13.1	FISS shall store the Part B coinsurance amount on the claim record and display it online using Value code 'Y3'.						X				
7887.14	The discharge date from the discharge bill shall be put on the CWF auxiliary record thereby closing it when the patient is discharged.						X			X	
7887.14.1	The hospital shall notify physicians who rendered services and submitted no-pay claims for Model 4 BPCI when an NOA is cancelled and that the services may now be eligible for payment under traditional Medicare Part B rules. **Note: The hospital notification to the physicians should indicate not to resubmit the claim or request an adjustment**										Model 4 hospital
7887.15	CWF shall create unique unsolicited responses for each type of "look back".									X	
7887.15.1	CWF shall initiate a "look back" into the claims history records upon receipt of a cancellation to an NOA to identify Model 4 BPCI claims- i.e., Part B physician or other professional claims - which were processed as "no pay" as a result of the NOA being opened. These claims may be identified by the demonstration number (64) on them.									X	
7887.15.2	CWF shall send an informational unsolicited response (IUR) to the contractor who originally processed the no-pay claims, directing the contractor that the claim be automatically adjusted.	X			X			X		X	
7887.15.3	Contractor shall adjust no pay claims as identified by	X			X			X			

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	the CWF IUR.										
	Related Readmissions										
7887.16	FISS shall add a new 1-byte field to the header claim level to carry one of the following Model 4 BPCI readmission indicators: • '1'- claim is a related readmission to a Model 4 BPCI claim, shall pay IME, DSH & Capital only. • '2'- two unrelated Model 4 BPCI claims within 30 days of each other, first claim in episode shall process as it would in the absence of Model 4 BPCI • '3' – two unrelated Model 4 BPCI claims within 30 days of each other, this is the second claim in the episode and paid as Model 4.						X				
7887.16.1	FISS shall pass the new field identified in 7887.17 to CWF.						X				
7887.16.2	CWF shall accept the new field identified in 7887.17 from FISS.									X	
7887.16.3	CWF shall pass the new field identified in BR 7887.17 to downstream systems.									X	
7887.16.4	Downstream systems shall accept the new field identified in 7887.17.										NCH, IDR, MEDPAR & FPS
7887.17	FISS shall check its history to determine whether to process the incoming IPPS claim as a readmission under Model 4.						X				
7887.17.1	FISS shall process incoming IPPS claims from Model 4 providers as they would be processed in the absence of BPCI Model 4 if either of the following are met: • Admission date of the incoming IPPS claim is within 30 days after the discharge date of a Model 4 claim in history from the same provider and the DRG on the incoming IPPS claim matches a DRG on the unrelated list • Admission date of the incoming IPPS claim is NOT within 30 days after the discharge date of a Model 4 claim in history from the same provider and the DRG is not on the provider's select list of Model 4 BPCI DRGs.						X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7887.18	FISS shall apply the readmission indicator '1' on an incoming IPPS claim if all of the following are met: • The incoming IPPS claim is from a Model 4 provider • The admission date of the incoming IPPS claim is within 30 days after the discharge from the same provider which was processed under Model 4 • The DRG on the incoming IPPS claim does not match a DRG on the unrelated admissions DRG list						X				
7887.18.1	CWF shall create an auxiliary record for the related readmission claim containing a readmission indicator '1'.									X	
7887.19	FISS shall process the incoming IPPS claim as a Model 4 claim and apply the readmission indicator '3' if all of the following are met: • Incoming claim is from a Model 4 provider • DRG on incoming claim is on the provider's select DRG list • DRG is not related to the Model 4 claim in history • The admission date of the incoming claim is within 30 days after the discharge date of Model 4 finalized claim from the same provider. Note: This is the 2nd claim in the episode. Example: History – 02/05/13 to 02/10/13 Model 4 BPCI Incoming – 03/02/13 to 03/10/13 Model 4 BPCI, '3'	X		X			X				
7887.19.1	FISS shall adjust the Model 4 finalized claim in history as follows: • Remove the demo code 64 • Apply the readmission indicator of '2' • Process as the claim would be processed in the absence of Model 4 BPCI • Process the adjustment to CWF. Note: This is the 1st claim in the episode. Example: History – 02/05/13 to 02/10/13 Model 4 BPCI, '2' Incoming – 03/02/13 to 03/10/13 Model 4 BPCI, '3'						X				
7887.19.1.	FISS shall also adjust the readmission claim within the						X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
1	2 Model 4 episodes in history, if present, as follows: Remove the readmission indicator of '1' Process as the claim would be processed in the absence of Model 4 BPCI. Process the adjustment to CWF. Example: History – 01/05/13 to 01/10/13 Model 4 History – 01/15/13 to 01/18/13 Readmission Ind '1' Incoming – 02/05/13 to 02/15/13 Model 4										
7887.19.2	FISS shall cancel the associated NOA of the previously finalized Model 4 claim that is now being adjusted. FISS shall cancel the NOA to the provider only (tape-tape flag =X). (CWF will cancel the NOA auxiliary file entry from the adjusted claim)						X				
7887.19.3	CWF shall cancel the matching auxiliary record upon receipt of an adjustment containing the readmission indicator '2' indicating "two Model 4 BPCI claims within 30 days of each other, first claim in episode shall pay as it would be paid in the absence of Model 4 BPCI".									X	
7887.19.4	CWF shall initiate a "look back" into the claims history records upon receipt of an inpatient claim with a readmission indicator '2' indicating claim was Model 4 but is being paid as it would be paid in the absence of Model 4 to identify Part B physician or other professional claims within the admit and discharge dates that processed as no pay.									X	
7887.19.5	CWF shall send an IUR to the contractor who originally processed the claims, directing the contractor that the claim be automatically adjusted to pay.	X			X			X		X	
7887.19.6	Contractor shall adjust no pay claims as identified by the CWF IUR.	X			X			X			
7887.20	CWF shall initiate a "look back" into the claims history records upon receipt of an inpatient Model 4 BPCI readmission claim (containing readmission indicator '1') to identify paid claims- i.e., Part B physician or other professional claims • Within or overlap the admit and discharge date of the incoming Model 4 BPCI readmission claim, or • on the admit and discharge date of the incoming Model 4 BPCI readmission claim when the POS code is 21									X	

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7887.20.1	CWF shall send one of the following two IURs to the contractor who originally processed the claims: • All dates of service on the Part B claim are within the Model 4 BPCI episode or are equal to the admit or discharge date with a POS 21; direct contractor to automatically adjust as a no-pay claim or • Dates of service are both outside the Model 4 BPCI episode (such as pre-admission and/or post-discharge office based services not covered under the Model 4 BPCI) and within a Model 4 BPCI episode; direct contractor to reject claim requesting provider rebill separate claims.	X			X			X		X	
7887.20.2	CWF shall NOT send an IUR on non-assigned Part B physician or other professional claims.									X	
7887.20.3	Contractor shall adjust claims as identified by CWF IURs and use Claim Adjustment Reason Code (CARC) / Remittance Advice Remark Code (RARC) codes as follows: • First bullet in 7887.20.1- CARC A1: Claim/Service denied and RARC N68: Prior payment being cancelled as we were subsequently notified this patient was covered by a demonstration project in this site of service. Professional services were included in the payment made to the facility. You must contact the facility for your payment. Prior payment made to you by the patient or another insurer for this claim must be refunded to the payer within 30 days. • Second bullet in 7887.20.1 - CARC 239: Claim spans eligible and ineligible periods of coverage. Rebill separate claims and RARC N61: Rebill services on separate claims.	X			X						
7887.21	Note: This scenario is to address claims submitted out of sequence, the 'related readmission claim comes in first'. FISS shall cancel the finalized IPPS claim in history if all the following are met: • The incoming IPPS claim is a Model 4 claim (demo code 64 present)	X		X			X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	• The discharge date of the incoming Model 4 claim is within 30 days prior to the admission date of a finalized claim from the same provider that is not a Model 4 claim • The DRG on the IPPS finalized claim in history is related to the incoming Model 4 BPCI claim (DRG is NOT on the unrelated list) All Model 4 BPCI hospitals shall be required to bill electronically using any Medicare approved standard formats. Example: History – 03/05/13 – 03/10/13 (processed FFS) Incoming – 02/12/13 to 02/25/13 Model 4										
7887.21.1	FISS shall assign a new reason code to identify the cancel claim as a readmission which should be resubmitted to receive the corrected payment.						X				
7887.21.2	If the DRG on the history claim is NOT related to the DRG of the incoming Model 4 BPCI claim (on the unrelated readmission list of DRGs), FISS shall continue processing the incoming claim as Model 4 BPCI.	X		X			X				
7887.22	FISS shall apply a readmission indicator code '2' to an incoming claim and process as it would be paid in the absence of Model 4 when all of the following are met: • Incoming claim is from a Model 4 provider • Incoming claim has a select DRG • Incoming claim has a discharge date within 30 days prior to the finalized Model 4 admission date. Example: History claim – 03/05/13 – 03/10/13 Model 4 Incoming claim – 02/02/13 – 02/25/13 Model 4	X		X			X				
7887.22.1	FISS shall adjust the Model 4 BPCI claim in history to add a readmission indicator '3' to identify this is the second Model 4 claim in an episode to be paid as Model 4.	X		X			X				
7887.23	The Payment Reconciliation contractor shall identify related readmissions from different facilities and recoup the amount paid from the original admitting hospital as well as any paid Part B physician or other										Payment Reconciliation contract

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	professional claims paid with dates of service within the admit and discharge date of the related readmission.										or
	Final discharge Billing by the Hospital										
7887.24	CWF shall verify a beneficiary's eligibility against a claim when an NOA is NOT present as follows: • Beneficiary is eligible for Part A and enrolled in Part B; • Beneficiary has met at least one lifetime reserve day on the date of admission; • Beneficiary does not have End Stage Renal Disease; • Beneficiary is not enrolled in any managed care plans; • Beneficiary must not be covered under the Railroad Retirement Board or United Mine Workers; and • Medicare must be the primary payer.									X	Model 4 hospital
7887.24.1	CWF shall reject the claim if any of the above beneficiary eligibility conditions are not met.									X	
7887.24.2	Contractors shall append condition code "B1" if any of the above beneficiary eligibility conditions are not met, remove demo code '64' and continue processing as it would in the absence of Model 4. Condition Code B1: *Beneficiary Ineligible for Demonstration Program", has been approved by the National Uniform Billing Committee to be used for these demonstrations effective 10/1/2001.*	X		X			X				
7887.25	FISS shall process the incoming claim as it would have in the absence of Model 4 BPCI when pricer return code equals 03, 05, 06, 10, 12, 33, 42, or 40.						X				
7887.25.1	FISS shall cancel the matching NOA if present for the final claim in 7887.25.						X				
7887.26	CWF shall create a new edit to indicate if the provider ID of the hospital billing for the Model 4 BPCI payment does not match the provider number of the hospital on the notice of admission.									X	
7887.26.1	CWF shall reject a Model 4 claim (demo code 64 present) if the claim matches an NOA for admission									X	

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	date and beneficiary, but not provider.										
7887.26.2	The contractors shall RTP the claim rejected by CWF in BR 7887.26.1 for the reason listed in the BR.	X		X							
7887.27	FISS shall create a new reason code to RTP a claim if an NOA is present for the claim (matches on provider, beneficiary and admission date), but the claim does not contain a DRG on the provider's select DRG list.	X		X			X				
7887.27.1	If an NOA is found but the DRG on the claim is not one covered under Model 4 BPCI, the claim shall be returned to the hospital. The hospital shall be instructed to cancel the NOA before re-submitting the bill.	X		X			X				
7887.28	If the Model 4 BPCI claim contains a participating Model 4 provider number, DRG covered under Model 4 BPCI, demonstration number 64 but a NOA is not present, CWF shall create an auxiliary file from the interim or final Model 4 BPCI claim.									X	
7887.29	CWF shall close the auxiliary record using the discharge date from the final Model 4 BPCI claim containing a demonstration number 64, matching provider number and admission date.									X	
7887.29.1	CWF shall initiate a "look back" into the claims history records upon receipt of an inpatient claim from a Model 4 BPCI provider to identify paid claims- i.e., Part B physician or other professional claims • Within or overlapping the admit and discharge date of the incoming Model 4 BPCI claim, or • on the admit and discharge date of the incoming Model 4 BPCI claim when the POS code is 21									X	
7887.29.1.1	CWF shall send one of the following two IURs to the contractor who originally processed the claims: • All dates of service on the Part B claim are within the Model 4 BPCI episode or are equal to the admit or discharge date with a POS 21; direct contractor to automatically adjust as a no-pay claim, or • Dates of service are both outside the Model 4 BPCI episode (such as pre-admission and/or post-discharge office based services not covered under the Model 4 BPCI) and within a Model 4 PBCI episode on the same claim; direct contractor to reject claim requesting provider	X			X			X		X	

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	rebill separate claims.										
7887.29.1.2	Contractor shall adjust claims as identified by CWF IURs and use CARC/RARC codes as follows: • First bullet in 7887.29.1.1 use o CARC 234: This procedure is not paid separately and o RARC N67: Professional provider services not paid separately. Included in facility payment under a demonstration project. Apply to that facility for payment, or resubmit your claim if: the facility notifies you the patient was excluded from this demonstration; or if you furnished these services in another location on the date of the patient's admission or discharge from a demonstration hospital. If services were furnished in a facility not involved in the demonstration on the same date the patient was discharged from or admitted to a demonstration facility, you must report the provider ID number for the non-demonstration facility on the new claim. • Second bullet in 7887.29.1.1 USE o CARC 239: Claim spans eligible and ineligible periods of coverage. Rebill separate claims and o RARC N61: Rebill services on separate claims.	X			X						
7887.30	If a Model 4 BPCI paid claim is cancelled, CWF shall cancel the matching record in the AUX file. A match consists of provider number, admit and discharge date.									x	
7887.30.1	CWF shall initiate a "look back" into the claims history records to identify Model 4 BPCI claims- i.e., Part B physician or other professional claims with dates of service within or overlapping the admit and discharge date or that equal the admit or discharge date with a POS 21 - which were processed as "no pay". These claims may be identified by the presence of demonstration number '64'.									X	
7887.30.1.1	CWF shall send an IUR to the contractor who originally processed the claims, directing the contractor that the claim be automatically adjusted to pay.	X			X			X		X	

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7887.31	CWF shall send all claims processed under Model 4 BPCI to the national claims history file.									X	
	BILLING FOR PHYSICIAN AND NON-PHYSICIAN PRACTITIONER										
7887.32	Physicians and non-physician practitioners shall submit claims for dates of service for an episode of care included in Model 4 BPCI as usual.										Physicians
7887.33	Physicians and non-physician practitioners shall be required to accept assignment for all claims covered under the Model 4 BPCI payment.										Physicians
7887.33.1	Contractors shall process claims from non-assigned providers with dates of service either within, overlapping or equal to the admission and discharge dates of a Model 4 BPCI episode as FFS.	X			X		X			X	
7887.34	Contractors shall pass the physicians allowed charges and number of services onto national claims history (NCH) and the Integrated Data Repository (IDR). Note: The physicians allowed charges are to be passed onto NCH in order to ensure the physician is included in determination of various Medicare incentive payment programs.	X			X			X		X	
7887.35	Physicians and non-physician practitioner's model-related claims which are processed by the A/B Medicare Administrative Contractor (MAC) on a "no pay" basis shall not be sent to any of the "screens" (e.g., surgery, cancer, etc.) in CWF.									X	
7887.36	Contractors shall process physician and non-physician practitioner claims for services that have coverage limits and/or would not be covered even in the absence of Model 4 BPCI according to normal business processes.	X			X						
7887.37	CWF shall reject the Part B physician and/or non-physician practitioner claim with an error code and trailer to indicate this is a Model 4 BPCI claim to be processed as a "no pay claim" if the dates of service are either: • Within or overlap the admit and discharge date of a Model 4 episode of care; or • on the admit and discharge date of a Model 4 episode of care when the POS code is 21									X	
7887.37.1	CWF shall return one of the following two error codes									X	

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	as appropriate to reject claims that include: • All dates of service on the Part B claim are within the Model 4 BPCI episode or are on the admit or discharge date of a Model 4 episode of care when the POS code is 21 (CARC 234 and RARC N67); or • Dates of service are both outside the Model 4 BPCI stay (such as pre-admission and/or post-discharge office based services not covered under the Model 4 BPCI) and within a Model 4 BPCI episode on the same claim (CARC 239 and RARC N61).										
7887.37.1.1	Contractors shall use the following remittance advice (RA) messages when rejecting claims that include "both" Model 4 related services and services rendered prior to and/or after the Model 4 BPCI episode: CARC 239: Claim spans eligible and ineligible periods of coverage. Rebill separate claims. RARC N61: Rebill services on separate claims.	X			X						
7887.37.2	Contractors shall process claims received from Part B physician and non-physician practitioners as no-pay claims based on a CWF error code or receipt of a CWF IUR when they occur as described in 7887.37.	X			X						
7887.38	CWF shall process the Part B physician and non-physician practitioner claim according to normal business processes when: • there is no NOA on file for the beneficiary, or • the dates of service are outside the episode of care, or • the dates of service are equal to the admission or discharge date and the POS is other than '21' and send a response back to the contractor as appropriate.									X	
7887.39	CWF shall "reject the Part B physician and non-physician practitioner claim with an error code and trailer 47 to indicate this is a Model 4 BPCI claim to be processed as a "no pay claim" when there is no discharge date on the NOA, but the date of service is after the date of admission on the NOA or equal to the	X			X			X		X	

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	admission date with a place of service (POS) 21										
7887.39.1	The SSM shall send a payment/denial code of "D" to CWF on claims with a Demonstration code of 64.							X			
7887.39.2	Contractors shall allow the Part B physician and non-physician practitioner claim when there is no discharge date on the NOA but the date of service on the Part B physician and non-physician practitioner claim is prior to the admission date of the NOA or equal to the admission date with a POS other than '21'.	X			X					X	
7887.40	Contractors shall process physician and non physician practitioner claims received on closed NOAs under existing claims processing rules when the date of service is after the discharge date or equal to the discharge date with a POS other than '21'.	X			X					X	
7887.41	The remittance advice sent to the physicians and non-physician practitioners should note the substituted payment provisions of the model.	X			X						
7887.42	Contractors shall use the following RARC code, N67, when processing physician claims as no pay: Professional provider services not paid separately. Included in facility payment under a demonstration project. Apply to that facility for payment, or resubmit your claim if: The facility notifies you the patient was excluded from this demonstration; or if you furnished these services in another location on the date of admission or discharge from a demonstration hospital. If services furnished in a facility not involved in the demonstration on the same date the patient was discharged from or admitted to a demonstration facility, you must report the provider ID number for the non-demonstration facility on the new claim.	X			X						
7887.43	The Demonstration ID number is **64**. There will be a single demonstration ID number for all hospitals participating in the Model 4 BPCI. Physicians billing for services that will ultimately be processed as 'no pay' claims should not submit claims with the demonstration ID number, however, the claims processing system will tag those claims when the trailer is received from CWF stating that there is an NOA on file for the date of service.							X			Physicians
7887.44	Physicians and other professional practitioners eligible	X			X			X			

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	for incentive payments shall continue to be eligible to receive these incentives to the same extent they would be in the absence of Model 4 BPCI.										
7887.45	MCS shall suppress all Medicare Summary Notices (MSNs) from the A/B MAC for "no pay" physician and non physician practitioner claims applicable to Model 4 BPCI patients.	X			X			X			
7887.45.1	Contractors shall not suppress MSN for FFS claims adjusted to be a "no pay" claims. Contractors shall use MSN message - 60.11 This payment is being retracted because the services provided are covered under a demonstration project in which the hospital receives payment for all physician and hospital services related to this admission. The provider should seek reimbursement directly from the hospital where the care was provided. Any deductible or coinsurance paid by you or your supplemental insurer (including Medicaid) for these services should be returned by the provider.	X			X			X			
7887.46	CWF and the SSM shall use all current edits (including current duplicate logic) on Model 4 BPCI claims. Auto-adjudication logic may still be applied.						X			X	
7887.47	Contractors shall count Model 4 claims as part of the normal monthly workload for CWF no payment bills.	X		X	X						
7887.47.1	Contractors shall use the MCS spitab table (HxxTDEMO) to report "no pay" claims for Model 4 BPCI episodes of care.	X			X						
	DEDUCTIBLES AND COINSURANCE										
7887.48	Crossover claims (i.e., claims where there is a Medigap insurer that shall pick up some of the patient payments) should continue to be processed in the same manner as they are under traditional processing.	X		X			X				
7887.49	CWF shall suppress the BOI trailer on Part B no pay claims that contain demo code 64. This will prevent Part B no pay claims from crossing over to trading partners.									X	
7887.50	CMS staff shall undertake efforts to educate Medigap insurers about Model 4 BPCI.										CMS
7887.51	FIs and A/B MACs shall continue to report any regular Part A coinsurance for a Model 4 BPCI claim (with claim adjustment group PR and reason code 2) in the RA. Coinsurance attributable to the Part B services that	X		X			X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	previously would have been paid by the FIs and/or A/B MACs for professional claims shall be reported using group PR and claim adjustment reason code 3 (copayment amount) with remark code M137 (Part B coinsurance under a global payment demonstration) at the claim level. PR signifies that the patient (or his/her other supplemental payer) is responsible for payment of this amount. Under Model 4 BPCI, the facility shall collect both types of coinsurance from the beneficiary or the beneficiary's supplemental payer. CMS shall differentiate between the types of patient liabilities for Medicare accounting purposes.										
7887.52	For bills submitted to CWF, the FIs and A/B MACs shall report the negotiated payment amount less any deductible or coinsurance amounts applicable, i.e., the amount paid to the provider, in the reimbursement field of the claims record. The A/B MAC processing the institutional claim shall compute what the applicable inpatient payment would have been under the traditional Medicare fee-for-service program, and other payment amounts in the value code area of the claims record as shown below. <u>Y1 Part A Demonstration Payment-</u> This is the portion of the payment designated as reimbursement for Part A services under the demonstration. This amount is instead of the traditional prospective DRG payment (operating and capital) as well as any outlier payments that might have been applicable in the absence of the demonstration. No deductible or coinsurance has been applied. Payments for operating IME and DSH which are processed in the traditional manner are also not included <u>Y2 Part B Demonstration Payment-</u> This is the portion of the payment designated as reimbursement for Part B services under the demonstration. No deductible or coinsurance has been applied.	X		X			X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	Y3 Part B Coinsurance- This is the amount of Part B copayment applied by the A/B MAC to this claim. For Model 4 BPCI claims this shall be a fixed copayment unique to each hospital and DRG. Y4 Conventional Provider Payment- Amount for Non-BPCI Model 4 Claims This is the amount Medicare would have paid the provider for Part A services if there had been no Model 4 BPCI. This should include the prospective DRG payment (both capital as well as operational) as well as any outlier payment, which would be applicable. It does not include any pass through amounts such as that for direct medical education nor interim payments for operational IME or DSH Y5 Part B Deductible- This is the amount of Part B deductible applied by the A/B MAC to this demonstration/model claim.										
7887.53	CWF shall return the Model 4 BPCI claim with one of 2 new edits when the Part B deductible is either under applied or over applied based on the value associated with new value code 'Y5'.									X	
7887.54	CWF shall create an indicator on the new auxiliary record that will display that the Part B deductible was satisfied on the Model 4 BPCI claim.									X	
7887.55	CWF shall apply the IUR process on posted VA outpatient or Part B physician and other professional claims with cash deductible applied when a Model 4 BPCI claim is processed and Part B deductible is applied.									X	
7887.56	FISS shall calculate the net reimbursement for a Model 4 (demo code 64 present) claim that has a finalized NOA as follows: (Part A Demonstration Amount + Part B Demonstration Amount) – Part A deductions (deductible, blood deductible, coinsurance and LTR amount) – Part B deductions (deductible and copayment) - $500.00+						X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	IME+DSH+Total capital.										
7887.57	FISS shall calculate the net reimbursement for a Model 4 (demo code 64 present) claim that does not have a finalized NOA as follows: (Part A Demonstration Amount + Part B Demonstration Amount) – Part A deductions (deductible, blood deductible, coinsurance and LTR amount) – Part B deductions (deductible and copayment) + IME+DSH+Total Capital.						X				
7887.58	FISS shall calculate the net reimbursement for readmissions (readmission indicator = 1) as follows: (IME+DSH+ Total Capital) – Part A deductions (deductible, blood deductible, coinsurance and LTR amount) – Part B deductions (deductible and copayment).						X				
7887.59	FISS shall create a new finalized reason code to identify that the claim was processed under Model 4.						X				
7887.60	FISS shall create a new finalized reason code to identify that the claim was processed as a readmission under Model 4.						X				
	MSN MESSAGE AND REMITTANCE ADVICE										
7887.61	Information regarding what would have been paid in the absence of Model 4 BPCI is not required to be put on the remittance advice sent to hospitals.	X		X			X				
7887.62	The following MSN messages shall be displayed as appropriate: **MSN Message - #** 32.2 You should not be billed separately by your physician(s) for services provided during this inpatient stay **MSN Message -** #60.2 The total Medicare approved amount for your hospital service is ($_____). ($_____) is the Part A Medicare amount for hospital services and ($_____) is the Part B Medicare amount for physician services (of which Medicare pays 80 percent). You are responsible for any deductible and coinsurance amounts represented. **MSN Message -** #60.11 60.11 - This payment is being retracted because the services provided are covered under a demonstration project in which the hospital receives payment for all physician and hospital services related to this admission. The provider should seek reimbursement directly from	X			X		X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	the hospital where the care was provided. Any deductible or coinsurance paid by you or your supplemental insurer (including Medicaid) for these services should be returned by the provider.										
	MISCELLANEOUS										
7887.63	The Model 4 BPCI claims data shall not be returned to the Automated Response Unit (ARU) system when the field 'Medicare Payment Sent (Y/N)' field has a value of "N".	X			X						
7887.64	Model 4 BPCI claims shall not be subject to appeals based on processing according to Model 4 BPCI specific requirements.	X			X						
7887.64.1	A/B MACs and Carriers shall determine if a Model 4 BPCI claim can be appealed for valid reasons unrelated to Model 4 BPCI processing.	X			X						
7887.64.2	Message N83 shall be used: **N83** No appeal rights. Adjudicative decision based on the provisions of a demonstration project.	X			X		X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	CR7782 - Affordable Care Act (ACA) Model 4 Bundled Payments for Care Improvement - Episode of Care - ANALYSIS ONLY
	CR7784 - Affordable Care Act (ACA) Model 4 Bundled Payments for Care Improvement Episode of Care Implementation Phase 1

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): For policy questions on the Model 1 Bundled Payments for Care Improvement program contact: Pamela Pelizzari at Pamela.Pelizzari@cms.hhs.gov.

For claims processing questions contact Louisa Rink at Louisa.Rink@cms.hhs.gov or Sarah Shirey-Losso at Sarah.Shirey-Losso@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs)*:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets

Section B: *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.