CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1260	**Date: July 25, 2013**
	Change Request 8318

NOTE: This Transmittal is no longer sensitive and is being re-communicated August 19, 2014 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 - Implementing Process for Provider Participation Decline

I. SUMMARY OF CHANGES: The Bundled Payments for Care Improvement initiative is being run under the CMS Innovation Center's model testing authority and is slated to be implemented in July 2013. This change request represents recently identified functionality that will be essential to the implementation of the initiative.

This change request implements functionality that will be needed under Model 4 of the Bundled Payments for Care Improvement initiative allowing physicians and non-physician practitioners who would prefer not to be involved with this program to decline participation. It extends the functionality of previously released instructions.

EFFECTIVE DATE: January 1, 2014
IMPLEMENTATION DATE: January 6, 2014

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
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

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SUBJECT: Affordable Care Act (ACA) Model 4 Bundled Payments for Care Improvement - Implementing Process for Provider Participation Decline

EFFECTIVE DATE: January 1, 2014
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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 2013.

This Change Request implements a process by which physicians can decline participation in the Bundled Payments for Care Improvement initiative, Model 4.

B. Policy: According to BPCI Model 4, hospitals participating will receive a prospectively established bundled payment for agreed upon MS-DRGs. The payment will include both the DRG payment for the hospital and a fixed amount for professional services anticipated to be rendered during the admission, as well as readmissions and professional services during those readmissions. Separate payment for physicians and non-physician practitioners' professional services rendered during the anchor Model 4 admission or any related readmissions to that Model 4 hospital 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 will 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.

The above stated policy extends the functionality of previously released instructions. With this CR, the addition of a HCPCS modifier will allow physicians and non-physician practitioners who wish to see their Medicare fee-for-service payments remain the same throughout BPCI Model 4 to decline participation in the program.

In the event that a physician or other practitioner would prefer to decline participation in the Model 4 payment arrangement, they can indicate this on their regularly submitted claim. If the physician or non-physician practitioner reports the "AO" (letters A and O) modifier on each HCPCS code, those services will be paid in accordance with the regular Fee-for-Service (FFS) payment rules. If a physician or non-physician practitioner does not report the "AO" modifier to each line of service on the claim then the claim shall be returned to the physician/non-physician practitioner as unprocessable with instruction to rebill the services on separate claims. If a physician or other practitioner submits a claim without indicating they prefer to decline participation, they may later resubmit that claim with the modifier on each line of service to indicate their preference to decline participation in the Model 4 payment arrangements and be paid in accordance with regular FFS payment rules. If this resubmission occurs after the physician or other practitioner has already been paid by the Model 4 hospital for that service, the Model 4 hospital will be required to recoup any payment made to that physician or other practitioner for that service such that only one payment is made (either by CMS or by the Model 4 hospital). If a physician or other practitioner chooses to decline participation in the Model 4 payment arrangement and thus is paid in accordance with regular FFS payment rules, they may also collect beneficiary coinsurance in accordance with these rules. In order to avoid requiring beneficiaries to pay excess coinsurance, the Model 4 hospital that collected the Model 4 coinsurance amount from the beneficiary would be required to refund to that beneficiary any coinsurance amount that was later collected by a physician who opted out. This would result in the beneficiary only being liable for the agreed upon Model 4 coinsurance amount.

Claims for related readmissions of Model 4 beneficiaries to hospitals other than the episode-initiating Model 4 hospital, as well as claims for Part B services furnished during such readmissions, will be paid under the regular applicable FFS payment rules. Those amounts, as well as the amounts paid to physicians and other practitioners who use the claims to decline participation in the process described above, will be recouped from the Model 4 Awardee through a quarterly payment reconciliation process, as they were already included in the Prospective Model 4 Payment that was paid to the Model 4 hospital.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8318.1	Physicians and non-physician practitioners shall report the "AO" modifier on each line of service on a claim to indicate that they have chosen to decline participation in the Model 4 payment arrangement.												Providers
8318.2	Effective for claims with dates of service on and after October 1, 2013, contractors shall accept the "AO" modifier on claims for physicians and/or non-physician practitioners who decline participation in the Model 4 payment arrangement.		X				X						

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8318.2.1	Contractors shall process claims with dates of service from October 1, 2013 - December 31, 2013, under Model 4 business rules when a physician/non-physician practitioner submits a claim with the "AO" modifier on each claim line.		X				X						
8318.2.2	Contractors shall not take any action related to the "AO" modifier for claims received prior to January 1, 2014.		X				X						
8318.3	Effective January 1, 2014 contractors shall process claims as FFS claims when the "AO" modifier is reported on every line of the claim.		X				X						
8318.4	CWF shall bypass Model 4 BPCI logic for physician and/or non-physician practitioner claims with the "AO" modifier reported on every line of the claim.											X	
8318.5	Effective January 1, 2014, contractors shall automatically adjust "no pay" claims that were processed with dates of service October 1, 2013 – December 31, 2013, to FFS claims when the "no pay" claims were submitted with the "AO" modifier reported on every line.		X				X			X			
8318.5.1	Contractors shall not take action to adjust claims with dates of service October 1, 2013 – December 31, 2013, when the "AO" modifier was not reported on every line of the claim. **Note:** *Physicians/non-physician practitioners would have to contact the MACs to initiate the appeals process to have these claims reprocessed with the "AO" modifier on every line.*		X				X			X			
8318.6	Effective January 1, 2014, contractors shall return claims as unprocessable when it is reported with the "AO" modifier AND the modifier is not reported on every line of		X				X						

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	service.												
8318.6.1	Contractors shall instruct physicians/non-physician practitioners to resubmit their claims and that in order to have their claims processed as FFS, the modifier must be on every line on the claim.		X				X						
8318.7	Contractors shall create a Supplemental Informational Hospital Demonstration Report to detail data from claims with place of service 21 that were reimbursed as FFS for physicians who submitted claims with the "AO" modifier on every line. **Note:** *The intent of this report is to collect informational data for utilization in the reconciliation process.*									X			
8318.7.1	Contractors shall use the same data elements as those used in the existing Model 4 Hospital Demonstration report for the Supplemental Informational Hospital Demonstration Report.									X			
8318.7.1.1	Contractors shall prepare the report on a weekly basis for each Model 4 BPCI hospital showing all claims from physicians/non-physician practitioners with the "AO" modifier processed in the previous week for services rendered at that Model 4 Hospital.									X			
8318.7.1.2	Contractors shall sort the Supplemental Informational Hospital Demonstration Report by facility NPI, HIC, rendering NPI, and date of service.									X			
8318.8	Contractors shall run and distribute the Supplemental Informational Hospital Demonstration Report in the same manner and in conjunction with the weekly Demonstration Hospital Report.									X			
8318.9	Model 4 BPCI hospitals shall refund the Part B												Hospital

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	coinsurance amount that was collected for the rendered services of a physician and/or non-physician practitioner when the provider has chosen to decline participation in the Model 4 payment arrangement.												
8318.10	Model 4 BPCI hospitals shall recoup monies paid to physicians and/or non-physician practitioners for "no pay" claims when physicians and/or non-physician practitioners are identified on the Supplemental Informational Hospital Demonstration report as having received reimbursement directly from Medicare for claims reported with the "AO" modifier on every line and processed as FFS claims.												Hospital
8318.11	The specialty contractor shall calculate monies to be recovered from Model 4 BPCI hospitals as result of the physician and non-physician practitioner claims submitted with the "AO" modifier on each line and reimbursed as FFS claims.												CMS Specialty Contractor
8318.12	CMS shall recoup monies paid as part of the bundled payment to Model 4 BPCI hospitals for physician and/or non-physician practitioner services reimbursed and detailed on the Supplemental Informational Hospital Demonstration report.												CMS
8318.13	The following MSN message shall be displayed as appropriate for claims submitted with the "AO" modifier on every line and processed as a FFS claim: MSN Message # 60.17 English - This provider isn't participating in a demonstration project or payment model program that recently covered services you received. You or your secondary insurer may get a refund from the admitting hospital. This refund will be automatic if it's owed.		X				X			X			

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	Spanish - Este proveedor no está participando en un programa piloto o en un programa de modelo de pago que cubra los servicios que usted recibió recientemente. Usted o su otro seguro podrían obtener un reembolso del hospital. Si le corresponde, recibirá el reembolso automáticamente.												
8318.14	Contractors shall use the following remittance advice (RA) messages when returning claims as unprocessable when claims include lines with and without the "AO" modifier: CARC 4: The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. RARC N517: Resubmit a new claim with the requested information.		X				X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
	None								

IV. SUPPORTING INFORMATION

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

"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): Pamela Pelizzari, Pamela.Pelizzari@cms.hhs.gov, Bridgitte Davis-Hawkins, Bridgitte.Davis-Hawkins@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), and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

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