CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-19 Demonstrations	Centers for Medicare & Medicaid Services (CMS)
Transmittal 145	**Date: April 28, 2016**
	Change Request 9625

SUBJECT: Update to the Common Working File Edits for G9678 - Oncology Care Model Service

I. SUMMARY OF CHANGES: This change request (CR) will update the current Common Working File (CWF) edits for Level II Healthcare Common Procedure Coding System (HCPCS) code G9678 - Oncology Care Model Service.

EFFECTIVE DATE: October 1, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 3, 2016

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

IV. ATTACHMENTS:
Demonstrations

Attachment - Demonstrations

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I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is for the Centers for Medicare and Medicaid Services (CMS) to update system edits established in CR9341 for the Oncology Care Model (OCM) Monthly Enhanced Oncology Services (MEOS) payment.

OCM is a 5-year model, beginning in July 2016, intended to utilize appropriately aligned financial incentives to improve care coordination, appropriateness of care, and access to care for beneficiaries undergoing chemotherapy. OCM encourages participating practices to improve care and lower costs through a model that incorporates a MEOS payment and episode-based payments. The CMS Innovation Center expects that these improvements will result in better care, smarter spending, and healthier people. Practitioners in OCM are expected to rely on the most current medical evidence and shared decision-making with beneficiaries to inform their recommendation about whether a beneficiary should receive chemotherapy treatment. OCM provides an incentive to participating physician practices to comprehensively and appropriately address the complex care needs of the beneficiary population receiving chemotherapy treatment, and heighten the focus on furnishing services that specifically improve the patient experience and/or health outcomes.

Practices that participate in OCM may receive MEOS payments of $160 (base rate) per beneficiary for care management and related practice transformation

B. Policy: This CR updates system edits established in CR9341 (OCM MEOS payment) to allow OCM practitioners under different Taxpayer Identification Numbers (TINs) to bill the MEOS payment for the same beneficiary during the same month. This CR instructs CWF to remove the edit created by BR 9341.1.10, thereby permitting CWF to allow detail lines containing the MEOS service when the date of service is in the same calendar month as another claim for the MEOS service for the same beneficiary. OCM rendering practitioners under the same billing provider may only bill the MEOS G code once per calendar month per beneficiary.

The OCM MEOS payment remains a base rate of $160, billable only by OCM practitioners, using G9678. Coinsurance and deductible payments by beneficiaries will not apply to G9678. G9678 will be subject to Medicare penalties and payment adjustments (e.g. VBM, EHR Incentive Program, PQRS reporting, sequestration, etc.). G9678 will not be subject to GPCI or budget neutrality adjustments. This policy was implemented in CR 9341.

CMS will review the paid claims for G9678, monitor for overpayment, and reprocess and recoup overpayments as described in a forthcoming CR.

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	
9625.1	CWF shall modify error code '5316' editing logic, implemented under BR 9341.1.10, to reject any detail line containing the G9678 - Oncology Care Model Service with a date of service on or after July 1, 2016, when the date of service is in the same calendar month as another claim with G9678 for that beneficiary with the same billing provider. **NOTE:** CWF shall allow detail lines with G9678 to process if the beneficiary has a claim for G9678 in the same calendar month with a **different** billing provider.								X	
9625.1.1	Contractors shall use the following messages for detail lines denied in BR 9625.1: CARC 119 - Benefit maximum for this time period or occurrence has been reached. Group Code: CO (Contractual Obligation) MSN 16.29 - Payment is included in another service you have received. Spanish language translation: El pago fue incluido en otro servicio que usted recibió.		X							
9625.2	CWF shall revise BR 9341.1.9 to remove the ESRD eligibility restriction.								X	
9625.2.1	CWF shall continue to confirm that the beneficiary at the time of the MEOS service was enrolled in both Medicare Parts A and B.								X	
9625.2.2	Contractors shall deny any detail lines that do not meet the eligibility requirements in BR 9625.2.1		X							
9625.2.2.1	Contractors shall use the following messages for detail lines denied in BR 9625.2.2 CARC 177 - Patient has not met the required eligibility requirements. Group Code: CO (Contractual Obligation) MSN 60.4 - This claim is being processed under a demonstration project. Spanish language translation: Esta reclamación está siendo procesada bajo un projecto especial.		X							
9625.3	If brought to their attention, contractors shall reprocess		X							

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
	any claims denied under BRs 9341.1.9 and 9341.1.10 with dates of service between July 1, 2016 and September 30, 2016, inclusive.									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C	C E D I
		A	B	H H H		
	None					

IV. SUPPORTING INFORMATION

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

"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): Ian Kramer, 410-786-5777 or ian.kramer@cmm.hhs.gov (Claims Processing Question) , Laura Mortimer, 410-786-2725 or laura.mortimer@cms.hhs.gov (Policy Questions)

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

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0