CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-19 Demonstrations	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10820	**Date: May 21, 2021**
	Change Request 11911

Transmittal 10746, dated April 27, 2021, is being rescinded and replaced by Transmittal 10820, dated, May 21, 2021 to revise Business Requirement (BR) 11911.1.4.1 adding the CARC information to the instruction, which includes a note in the BR. All other information remains the same.

SUBJECT: Primary Care First (PCF) and Serious Illness Patient (SIP) Models: Part 3: IURs and Edits for Non-Sequential Claims

I. SUMMARY OF CHANGES: The Innovation Center has secured approval for a new Primary Care First (PCF) model with two separate but related components: (1) the PCF component and (2) the Seriously Ill Population (SIP) component. Both components will test alternative payments and the provision of technical support to primary care practices. Practices may participate in one or both components, although individual beneficiaries may only be covered under one component at a time. Primary care practices participating in PCF and/or SIP will receive a combination of claims and non-claims-based payments based on their attributed Medicare fee-for-service (FFS) beneficiaries. With fewer reporting requirements, PCF-only practices will have the flexibility to implement their own strategies that best target outcomes within PCF. SIP-only practices will deliver care to a separate patient population that is both higher risk and shows fragmented patterns of care. This CR is a follow-on to CRs 11419 and 11896.

EFFECTIVE DATE: April 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 5, 2021

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

Pub. 100-19	Transmittal: 10820	Date: May 21, 2021	Change Request: 11911

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SUBJECT: Primary Care First (PCF) and Serious Illness Patient (SIP) Models: Part 3: IURs and Edits for Non-Sequential Claims

EFFECTIVE DATE: April 1, 2021
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I. GENERAL INFORMATION

A. Background: Section 1115A of the Social Security Act established a new Center for Medicare and Medicaid Innovation (the Innovation Center) within the Centers for Medicare & Medicaid Services (CMS) to test new payment and service delivery models that have the potential to reduce Medicare, Medicaid, and CHIP expenditures while maintaining or improving the quality of care for beneficiaries.

The Innovation Center has secured approval for a new Primary Care First (PCF) model with two separate but related components: (1) the PCF component and (2) the Seriously Ill Population (SIP) component. Both components will test alternative payments and the provision of technical support to primary care practices. These PCF and/or SIP participants will receive a combination of claims and non-claims-based payments based on their attributed Medicare fee-for-service (FFS) beneficiaries. With fewer reporting requirements, PCF component practices will have the flexibility to implement their own strategies that best target outcomes. SIP component practices will deliver care to a separate patient population that is both higher risk and shows fragmented patterns of care.

Participants in the PCF model are primary care practices that may participate in one or both components, although individual beneficiaries may only be covered under one component at a time. A primary care practice may include one or more physicians, as well as non-physician providers such as nurse practitioners. Every participating practice will be given a unique practice ID by the CMS implementation support contractor. Providers in a practice will be uniquely defined by the combination of each provider's tax ID number (TIN) and national provider identifier (NPI).

The first cohort of PCF and SIP component participants will begin operation during the following dates:

• PCF component: January 1, 2021 – December 31, 2025

• SIP component: April 1, 2021 – December 31, 2025

The second cohort of PCF and SIP component participants will start one year after the first PCF component cohort:

• PCF and SIP components (Cohort #2): January 1, 2022 – December 31, 2026

CMS will create a provider file that lists all participating providers, their PCF component and/or SIP component practice affiliation, and the effective and termination dates of their participation in the PCF model. A given provider (as defined by the concatenation of TIN and NPI) may only be active in one PCF practice at a time. Providers within a practice may have different effective and termination dates (e.g., as they are hired or leave the practice), but the practice itself will have its own effective and termination date for participation in the model. CMS will also create a beneficiary file detailing all attributed (which is also referred to as aligned) Medicare FFS beneficiaries to participants in PCF and/or SIP components. CMS will detail all information specific to the provider and beneficiary files within the Interface Control Document (ICD). CMS will upload this file in the following location within eCHIMP:

- Change Request (CR) Form/Files/Interface Control Documents

Please note this PCF CR is a follow-on to CRs 11419 and 11896 and addresses the following objectives for the April 2021 Release regarding non-sequential claims for beneficiaries under the SIP component:

- Processing Appendix A HCPCS codes under FFS rules for SIP beneficiaries when there is not any paid claim line of HCPCS code G2020
- Previously processed Appendix A HCPCS codes under traditional FFS shall be reprocessed as FVF claims with demonstration code "96" if an incoming paid HCPCS code G2020 is processed with a date of service at least one day prior.

B. Policy: Under the Primary Care First (PCF) and Seriously Ill Population (SIP) models, the Innovation Center will engage up to 8,000 primary care practices respectively. Practices may participate in either or both of the models at the same time. While beneficiaries may be eligible for both and, in fact, it is likely that some beneficiaries who start out as SIP participants will transition to participation in PCF, beneficiaries shall only participate in one component of the model at a time.

Under the model, PCF/SIP participating providers shall continue to bill evaluation and management (E&M) and other HCPCS codes (under Appendix A) for all patients as they normally do under the traditional Medicare program. For beneficiaries attributed to them, however, the payment for services covered under the model (listed in Appendix A) will be paid at a geographically adjusted flat visit fee (FVF) amount per visit. Please note the FVF will not vary by HCPCS code. Participating providers submitting multiple HCPCS codes on the same date of service for the same beneficiary will receive one FVF from Medicare. Under the PCF/SIP model, beneficiary cost sharing shall remain unchanged and should adhere to traditional fee for service.

The beneficiary attribution process will be conducted outside of the claims system although a list of beneficiaries attributed to each model shall be provided to contractors for the purposes of claims adjudication every month. Patient coinsurance and deductible will, however, be calculated based on traditional fee for service processing for the original E&M code that the provider billed. The FVF also waives the 15% reduction on claims submitted by non-physician providers. The removal of the 15% reduction shall take effect after coinsurance has been applied so that beneficiaries are not adversely impacted by increased coinsurance.

In addition, SIP participating providers shall also be eligible to bill for a one-time initial visit fee with a SIP beneficiary: HCPCS Code G2020 prolonged initial face-to-face visit. G2020 shall not be subject to coinsurance and deductible and only one SIP code shall be paid per the lifetime of each SIP beneficiary. Similar to the FVF, the PCF model will waive the 15% non-physician provider reduction for G2020.

The G2020 service must be provided and billed at least one day before any other services subject to the flat visit fee may be reimbursed accordingly. In the event HCPCS code G2020 is provided after OR on the same

date of service as FVF HCPCS codes, the following will occur for SIP beneficiaries only:

- If the HCPCS code G2020 has the same date of service as FVF HCPCS codes, CMS shall deny claim lines with any FVF HCPCS codes
- If an FVF HCPCS code has been rendered prior to HCPCS code G2020 experience, the claim lines with FVF HCPCS codes will be processed under traditional FFS.

Separate from these PCF and SIP component FFS payments, PCF/SIP participating providers may receive per beneficiary per month payments for attributed beneficiaries as well as performance-based payments. These payments shall be processed outside the fee for service claims processing system and do not require input from FFS contractors.

PCF/SIP participating providers are prohibited from billing HCPCS Codes listed in Appendix B on any of their attributed beneficiaries. CMS has determined Appendix B HCPCS Codes (99487, 99489, 99490, 99491, 99339, and 99340) are duplicative of the non-claims-based payments participants are receiving under PCF and/or SIP components.

Except as otherwise specified, PCF/SIP claims shall be subject to all other adjustments (e.g., sequestration) and policies applicable to other fee for service claims.

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	
11911.1	CWF shall check the SIP beneficiary record for HCPCS code G2020 prior to processing FVF or Appendix B claims. If the SIP beneficiary record has a paid G2020 claim with a date of service one or more days prior to the FVF date of service, then the claim shall be processed and paid as FVF under the rules of the PCF/SIP model. If the SIP beneficiary record has a paid G2020 claim with a date of service one or more days prior to the Appendix B HCPCS code, then the claim shall be rejected under the rules of the PCF/SIP model. **Notes:** 1: Claim details for FVF services are identified by having a benefit enhancement flag of 'E'. 2: The provider who billed the G2020 code need not be the same as the provider billing the FVF eligible code or Appendix B HCPCS code.								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	3: This will only apply to SIP beneficiaries where the Population Indicator is equal to 'S' on the beneficiary alignment file. 4. Claim details for Appendix B services are identified by having the benefit enhancement flag of 'E' and demo code '96'.									
11911.1.1	CWF shall create a new utilization edit to reject the FVF or Appendix B services if the beneficiary is a SIP beneficiary and a claim with demonstration code "96" is processed, but there is no paid HCPCS G2020 (indicated on SURG AUX file or within the same claim) with a date of service one or more days prior to the FVF or Appendix B service date. **Notes:** 1. Providers can be different. Only applies to SIP Benes. 2. Claim details for FVF services are identified by having a benefit enhancement flag of 'E'. 3. Claim details for Appendix B services are identified having a benefit enhancement flag of 'E'.								X	
11911.1.2	For SIP beneficiaries, CWF shall check the beneficiary record for HCPCS code G2020 prior to processing FVF or Appendix B claims. If the SIP beneficiary record does not have a paid G2020 claim with a date of service one or more days prior to the FVF or Appendix B date of service, then the FVF or Appendix B claim shall be processed and paid as traditional FFS. **Note:** For SIP beneficiaries, claims that contain HCPCS codes listed in Appendix A or Appendix B that are processed under traditional FFS shall have the demonstration code '96' removed.								X	
11911.1.3	MCS shall bypass demo pricing and pay as traditional Medicare FFS when a reject is received from CWF; MCS shall send the claim back to CWF without demonstration code '96' and benefit enhancement						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	indicator 'E'.									
11911.1.4	If a SIP beneficiary has previously processed traditional FFS for procedures in Appendix A or Appendix B and an incoming paid G2020 is processed with Date of Service at least one day prior to the Appendix A or Appendix B date of service in history, CWF shall create a new IUR to reprocess the following traditional FFS claims accordingly: • Appendix A as FVF instead with demonstration code "96" and benefit enhancement indicator "E". • Appendix B as a denied claim with demonstration code "96" and benefit enhancement indicator "E". This should apply the new IUR for all HCPCS codes under Appendix A and Appendix B after G2020 date of service.		X				X		X	
11911.1.4.1	Contractors shall use the following messages for claim lines reprocessed and paid in accordance with the rules of the PCF/SIP model, unless otherwise specified in this CR: Claims Adjustment Reason Code (CARC): 132 "Prearranged demonstration project adjustment" Remittance Advice Remark Code (RARC): N83 “No appeal rights. Adjudicative decision based on the provisions of a demonstration project." Group Code: CO (Contractual Obligation) MSN 60.4: This claim is being processed under a demonstration project. Spanish Translation: Esta reclamación está siendo procesada bajo un proyecto especial.		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	NOTE: The CARC 132 will only display on the remittance for the reprocessed claim when there is a difference between the original claim paid amount and the reprocessed claim paid amount.									
11911.1.4.2	For PCF/SIP participating providers, contractors shall deny claim lines that contain HCPCS codes listed in Appendix B and shall use the messages below: Claims Adjustment Reason Code (CARC): 132 "Prearranged demonstration project adjustment" Remittance Advice Remark Code (RARC): N83 "No appeal rights. Adjudicative decision based on the provisions of a demonstration project." Group Code: CO (for contractual obligation) MSN 60.4: This claim is being processed under a demonstration project. Spanish Translation: Esta reclamación está siendo procesada bajo un proyecto especial.		X							
11911.1.5	Contractors shall generate an adjustment due to the IUR from CWF to reprocess as a demonstration code '96' claims with Appendix A or Appendix B HCPCS codes with a date of service occurring after the date of service submitted with HCPCS code G2020.		X				X			
11911.2	A/B MAC Part B Contractors shall process PCF/SIP IUR adjustment with Shared System Reason Code 'O' and an appropriate Discovery Code. **Note: A/B MAC Part B contractors shall use any of the existing Discovery Codes based on the determination if CMS, MAC, or Provider initiated the overpayment.**		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11911.3	A/B MAC Part B Contractors shall handle all PCF/SIP model claims and/or claim lines as non-935 eligible. **Note: PCF/SIP model claims and/or claim lines are not eligible for 935 appeal rights.**		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	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

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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: 2

Primary Care First (PCF)

Appendix A

Flat Visit Fee (FVF) HCPCS Codes

HCPCS Codes	Service Type
99201	Office/Outpatient Visit E/M
99202	Office/Outpatient Visit E/M
99203	Office/Outpatient Visit E/M
99204	Office/Outpatient Visit E/M
99205	Office/Outpatient Visit E/M
99211	Office/Outpatient Visit E/M
99212	Office/Outpatient Visit E/M
99213	Office/Outpatient Visit E/M
99214	Office/Outpatient Visit E/M
99215	Office/Outpatient Visit E/M
99324	Home Care E/M
99325	Home Care E/M
99326	Home Care E/M
99327	Home Care E/M
99328	Home Care E/M
99334	Home Care E/M
99335	Home Care E/M
99336	Home Care E/M
99337	Home Care E/M
99341	Home Care E/M
99342	Home Care E/M
99343	Home Care E/M
99344	Home Care E/M
99345	Home Care E/M
99347	Home Care E/M
99348	Home Care E/M
99349	Home Care E/M
99350	Home Care E/M
99354	Prolonged E/M
99355	Prolonged E/M
99495	Transitional Care Management Services
99496	Transitional Care Management Services
99497	Advanced Care Planning
99498	Advanced Care Planning
G0402	Welcome to Medicare
G0438	Annual Wellness Visits
G0439	Annual Wellness Visits
99415	Prolonged Clinical Services
99416	Prolonged Clinical Services

Primary Care First (PCF)

Appendix B

Prohibited HCPCS Codes

HCPCS Codes	Service Type
99487	Chronic Care Management
99489	Chronic Care Management
99490	Chronic Care Management
99491	Chronic Care Management
99339	Home Care
99340	Home Care
G2211	Primary Care Management
G2212	Prolonged Evaluation & Management
99439	Chronic Care Management