PROGRAM MEMORANDUM INTERMEDIARIES/CARRIERS

Department of Health and Human Services

Health Care Financing Administration

Transmittal No. AB-00-42 **Date MAY 2000**

CHANGE REQUEST 1116

SUBJECT: Claims Processing Instructions for the Medicare Coordinated Care Demonstration

This Program Memorandum contains instructions for contractors to use in processing claims received after September 30, 2000, with dates of service October 1, 2000 or later, for the Medicare Coordinated Care Demonstration (MCCD). The study involves the evaluation of case management and disease management approaches to care for certain chronically ill beneficiaries.

Background

As required by the §4016 of the Balanced Budget Act (BBA) of 1997, HCFA is conducting the MCCD to test whether coordinated care services furnished to certain beneficiaries improve outcomes of care and reduce Medicare expenditures under Parts A and B. The coordinated care services will be provided by entities whose approach follows either a case management model or a disease management model. There will be at least nine Coordinated Care Entities (CCEs) selected for the demonstration through a national solicitation. The selected entities will be assigned a provider number specifically for the demonstration services. Beneficiary participation in the demonstration will be voluntary. In addition, up to two of the beneficiaries' physicians who contribute significantly to the ongoing management and oversight of the beneficiary's plan of care will be permitted to submit claims for these management services and/or services furnished during scheduled team conferences. Physicians will use their normal provider identifiers when submitting claims for coordinated care services.

A monthly coordinated care fee will be paid for each calendar month, or portion of a month, for which the CCE bills for coordinated care services furnished to a beneficiary who is "enrolled" in the demonstration during that month. Claims may be submitted only after the coordinated care services have been rendered. The coordinated care fee includes payment, in full, for all case management or disease management services and for any and all flexible benefits furnished to the beneficiary by the CCE (see below). In addition, CCE's may bill for home infusion services on a periodic basis, not to exceed once per day (rates and codes will be furnished prior to implementation).

The package of coordinated care services to be furnished and the targeted beneficiaries will vary at each demonstration site. At a given site, the level of intensity of services furnished will vary for each beneficiary served, according to their individual health needs as determined by the coordinated care entity. In addition to care management, patient education, and monitoring, the coordinated care services will include some services that typically are considered non-covered or not separately payable for Medicare purposes. These "flexible benefits" may include: transportation, medications, medication regime review by a pharmacist, equipment (scales, pill boxes, etc.), group patient education sessions, extensive rehabilitation services, diet and exercise training, etc. An implementation contractor or the demonstration project officer will be used to collect information directly from the demonstration sites regarding the flexible benefits furnished to beneficiaries. There will be no standard system involvement in this information collection process.

Two new payment amounts will be established for beneficiaries' physicians who manage and oversee the plan of care implemented by the coordinated care entity. Up to two of the beneficiaries' physicians may bill for monthly coordinated care oversight services (HCPCS code G9008) furnished in conjunction with the demonstration coordinated care entity. In addition, up to two of the enrolled beneficiaries' physicians may bill for services furnished during a scheduled team conference (HCPCS code G9007) with the patient, family members/care givers, and care manager. The number of scheduled team conferences allowable is limited to two per calendar year per physician per enrolled beneficiary. Payment will be made to the service provider at 100 percent of the approved amount and beneficiary participants will NOT be liable for a coinsurance amount for the physician coordinated care oversight services nor for the allowable scheduled team conferences. No Part B deductible will be applicable to these services.

The BBA requires that there be at least nine sites (five urban, three rural, and one in the District of Columbia—the Georgetown University Medical Center (GUMC)). Each site will have at least 300 enrollees per year. Implementation for the GUMC site is scheduled for October 2000. The other sites will be selected through a competitive process beginning in early 2000. The remaining sites will begin implementation in January 2001. Operation of the demonstration will continue for 4 years, and, if cost-effective, will be extended and possibly expanded.

Enrollment

A Notice of Election (NOE) transaction will be used to enroll, dis-enroll, change, and delete elections by beneficiaries to participate in the demonstration. These enrollment procedures are similar to those utilized for Religious Non medical Health Care Institutions (RNHCI). The Common Working File will load the NOE transactions into an auxiliary history file that stores the MCCD information (date of election, date of revocation, site's provider number, and indicators for demonstration claims paid). Beneficiaries must be enrolled in Part A and Part B to be eligible for enrollment in the demonstration. Medicare must be the primary payer. Beneficiaries enrolled in managed care organizations are not to be included in the demonstration.

Enrollment can occur at any time in the calendar month.

Responsibilities of Intermediary

The intermediary will be responsible for processing election notices submitted by the CCEs and for demonstration services performed in an outpatient setting.

Appropriate Bill Types

CCEs utilize bill type 84X. CCEs will utilize the UB-92 flat file and will use record type 40 to report the bill type. Record Type (Field No. 1), Sequence Number (Field No. 2), Patient Control Number (Field No. 3), and Type of Bill (Field No. 4) are required. CCEs utilizing the X12 837 version 3051 (837) will use 2-130-CLM.

CWF Notification of Elections

CCE's submit a notice of election to the intermediary for beneficiary elections made on or after October 1, 2000. This means for MCCD beneficiaries who are enrolled for participation in the MCCD on or after October 1, 2000, the CCE must submit an election notice to the intermediary for processing.

CCE's must use the UB-92 flat file or 837 as an election notification. CWF will transmit a disposition 01 to notify the intermediary that the notification of election was received. CCE's must submit the NOE and receive notification that the election was received prior to billing for demonstration related services.

CWF Notification of Revocations

CCE's submit a UB-92 flat file or 837 as an election notification to the intermediary as a notice of revocation for a previously posted MCCD election when an MCCD beneficiary submits a written request to the CCE revoking his/her participation in the MCCD. CWF will transmit a disposition 01 to notify the intermediary that the notification of revocation was received.

CWF Notification of Cancellations to Notifications of Elections and Revocations

CCE's submit a UB-92 flat file (bill type 84X) to the intermediary as a cancellation of a previously submitted notice of election or notice of revocation, when they were submitted in error. In situations where the CCE is correcting a previously submitted date, they submit a new UB-92 flat file or 837 (bill type 84X) to the intermediary for processing. CWF will transmit a disposition 01 to notify the intermediary that the notification of cancellation was received.

Completion of the Notice of Election by CCE's

Record Type (RT) 10, Fields 11- 16. Provider Name, Address, and Telephone Number (Required). The minimum entry is the provider's name, city, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine digit ZIP codes are acceptable. Use the information to reconcile provider number discrepancies. FAX numbers are desirable. Enter the corresponding 837 data in 2-040-PER, 2-015-NM1, 2-025-N3, and 2-030-N4.

RT 40, Field 04. Type of Bill (Required). Enter the three-digit numeric type of bill code: 84A, 84B or 84D as appropriately. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular enrollment. It is referred to as a "frequency" code. Enter the corresponding 837 data in 2-130-CLM.

Code Structure

1st Digit - Type of Facility.

8 Special Facility

2nd Digit - Classification.

4 Other

3rd Digit - Frequency.

A - election notice
B - revocation notice
D - cancellation

RT 20, Fields 4-6. Patient's Name (Required). Show the patient's name with the surname first, first name, and middle initial, if any. Enter the corresponding 837 data in 2-095-NM1.

RT 20, Fields 12-16. Patient's Address (Required). Show the patient's full mailing address including street name and number, post office box number or RFD, city, State, and ZIP code. Enter the corresponding 837 data in 2-105-N3 and 2-110-N4.

RT 20, Field 8. Patient's Birth Date (Required). (If available.) Show date of birth numerically as CCYYMMDD. If the date of birth cannot be obtained after a reasonable effort, zero fill the field. Enter the corresponding 837 data in 2-115-DMG02.

RT 20, Field 7. Patient's Sex (Required). Show an "M" for male or an "F" for female. Enter the corresponding 837 data in 2-115-DMG03.

RT 20, Field 17. Admission Date (Required). Enter the admission date. In no instance should the admission date be prior to October 1, 2000. Show the date numerically as CCYYMMDD. Enter the corresponding 837 data in 2-135.B-DTP03.

RT 10, Field 6. National Provider Identifier (Required). This is the six-digit number assigned by Medicare. Enter the corresponding 837 data in 2-005-PRV03.

RT 30, Fields 12-14. Insured's Name (Required). Enter the beneficiary's name on line A if Medicare is the primary payer. Show the name as on the beneficiary's HI card. Enter the corresponding 837 data in 2-325.B-NM1.

RT 30, Field 7. Certificate/Social Security Number and Health Insurance Claim/Identification Number (Required). Show the number as it appears on the patient's HI card, Social Security Award Certificate, utilization notice, MSN or EOMB, temporary eligibility notice, etc., or as reported by the SSO. Enter the corresponding 837 data in 2-095-NM109.

A CCE representative will ensure an original, signed MCCD election statement has been sent to the intermediary and they have retained a copy in their records.

Billable Codes Under the MCCD

Several new billable codes (HCPCS) will be assigned for the purposes of this demonstration. See Attachment I for a list of these codes and their descriptors.

Denial of Services Provided in the MCCD

Ensure that none of your local medical review policies inappropriately denies claims for the new billable codes under this demonstration. In situations where (upon appeal, etc.) you become aware that certain claims for demonstration services were inappropriately denied, allow payment for eligible beneficiaries who participate in the MCCD.

CWF Validation of Claims Submission

As noted above, the CWF will capture the enrollment and history information for the demonstration. CWF will validate and edit each claim submitted with the MCCD special processing number 37 to ensure that:

- The beneficiary HIC number appears on the auxiliary file;
- The beneficiary has not been terminated;
- The date(s) of service is (are) within the beneficiary's participation period;
- The claims submitted for coordinated care services, physician coordinated care oversight services, scheduled team conferences, and home infusion services do not exceed the number of allowed frequencies; and
- The beneficiary has both Part A and Part B coverage.

If a claim fails one or more of these validation and edit checks, the claim will be rejected by CWF with the appropriate reject message.

Claims Processing Instructions for Both Intermediaries and Carriers

Claims for the special MCCD HCPCS codes must be submitted electronically by the providers. Paper claims for these services will be returned to the providers by the intermediary or carrier.

The intermediary that has jurisdiction for processing Part A claims for the GUMC site serving Maryland and the District of Columbia is Blue Cross Blue Shield of Maryland.

The carrier that has jurisdiction for processing physician claims for the GUMC demonstration site is Trailblazers Health Enterprises, LLC, The jurisdiction is Maryland and the District of Columbia and in Virginia, the City of Alexandria, Arlington and Fairfax Counties.

The intermediaries and carriers with jurisdiction for processing claims from the other demonstration sites will be determined after site selection.

The following are the standard systems affected by the GUMC demonstration site:

FISS (Part A), MCS (EDS) (Part B)

Carriers will be able to identify claims for the MCCD from the special processing number 37 that will be submitted on the claim form by the providers participating in the demonstration.

Intermediaries will be able to identify claims for the MCCD from the special condition code "B0" that will be submitted on the claim form by the providers participating in the demonstraiton.

RT 41, Fields 4-13. Demonstration Condition Code (Required) U. Condition code "B0" (Letter B, Number zero; pending NUBC approval) will be entered here to identify the claim to the intermediary as a coordinated care demonstration claim.

Do not publish provider billing instructions for the demonstration. HCFA will release all necessary information concerning how providers should submit claims to the demonstration sites. The sites will share this information with the physicians furnishing the demonstration services to the participating beneficiaries. Provider inquiries regarding how to submit bills for demonstration services will be referred to the demonstration implementation contractor or the demonstration project officer. However, contractors will continue to assist the providers in resolving claims processing issues that pertain to billing procedures or coverage policy outside the scope of the demonstration.
The demonstration claims will not be subject to the Part A and B deductible and coinsurance where applicable.

All contractors will ensure that necessary systems changes are installed to ensure that the demonstration ID number (SPN 37) is moved (or written) to the proper location on the claim for CWF to carry it to the national claims history file.

Provider Remittance Notices

Use the following group, claim adjustment reason, and remark codes to report demonstration- related denials to providers. Under the terms of the demonstration, beneficiaries are not liable for payment of services denied for the following reasons. As with any denials, include an appropriate appeal remark code message for the claim. Notify potential electronic remittance advice (ERA) recipients of new remark codes and their meaning prior to initial transmission of the code in an ERA.

1. Services denied as CWF was unable to locate any record that the patient was approved to participate in the demonstration at the time services were rendered, and coverage is limited to demonstration participants. This would apply if the patient never enrolled, the enrollment had not been approved as of the date(s) of the service(s), or the patient's application for enrollment was rejected for failure to meet enrollment conditions. Report group code CO and adjustment reason code 96 (non-covered charges) at the line level, and new line level remark code M138 (Patient identified as a demonstration participant but the patient was not enrolled in the demonstration at the

time services were rendered. Coverage is limited to demonstration participants).

2. Billed services exceed the coverage limit established for the demonstration. Report group code CO and adjustment reason code 35 (Benefit maximum has been reached) at the line level, and new line level remark code M139 (Denied services exceed the coverage limit for the demonstration). Pay for the services which do not exceed the coverage limit; do not deny or reject the entire claim.

When issuing pre-version 3051.4A.01 X12.835 ERA transactions that are not capable of reporting line level data, or of paper remittance notices which are also unable to report line level data, intermediaries must split demonstration-related claims that contain both covered and non-covered services. The Fiscal Intermediary Standard System (FISS) maintains separate flat files for line level and non-line level capable ERA and paper remittance notices. Report CO 96 with M138 and/or CO 35 with M139 as appropriate at the claim level for non-version 3051.4A.01 remittance notices when claims, or a split portion of a claim, are denied for these reasons.

Due to the differences between paper remittance notice reporting and version 3051.4A.01 ERA reporting, intermediaries are not allowed to issue both a paper remittance notice and send a version 3051.4A.01 transmission to a provider for the same claim. (MIM Part 3, §3750 already prohibits issuance of "a hard copy version of the 835, in addition to the electronic transmission, in production mode.") Providers must use PC-Print to generate a paper version of their ERA, if they need a paper copy.

MSN Messages

In situations where a demonstration service is rejected by CWF because the auxiliary file does not contain that beneficiary's HIC number as a participant in the demonstration, deny the service using the following message:

"A claim has been submitted on your behalf indicating that you are participating in the Medicare Coordinated Care Demonstration project**.** However, our records indicate that you are not currently enrolled or your enrollment has not yet been approved for the demonstration." (EOMB Message #60.6, MSN# 60.6.)

Spanish language version:

"Una reclamción de reembolso ha sido sometida en su nombre indicando que usted está participando en el Projecto de Prueba de Cuidado de Salud Coordinado de Medicare. Sin embargo, nuestros archivos indican que usted no está afiliado al presente o su afiliciación todavía no ha sido aprobada para participar en este projecto de prueba." (EOMB Message #60.6, MSN# 60.6.)

In situations where a demonstration service is rejected by CWF because the dates of services are outside of the demonstration participation dates contained in the auxiliary file, i.e., the file indicates that the beneficiary terminated his/her election of participation in the demonstration, deny the service using the following message:

"A claim has been submitted on your behalf indicating that you are participating in the Medicare Coordinated Care Demonstration project**.** However, our records indicate that you have either terminated your election to participate in the demonstration project or the dates of service are outside the demonstration participation dates. " (EOMB Message #60.7, MSN# 60.7.)

Spanish language version:

"Una reclamación de reembolso ha sido sometida en su nombre indicado que usted está participando en el Projecto de Prueba de Cuidado de Salud Coordinado de Medicare. Sin embargo, nuetros archivos indican que usted o decidió terminar su participación en el projecto de prueba o los días de servicios están excluídos de los días de participación del projecto de prueba." (EOMB Message #60.7, MSN# 60.7.)

Reopen and adjust any erroneously denied MCCD claims brought to your attention. This may occur in situations where the NOE was not submitted properly or timely by a CCE.

Carrier Claims Processing

When you are notified that CWF is ready to accept MCCD claims, begin processing Medicare claims for dates of service on or after October 1, 2000 based upon these instructions. Restrict coverage for coordinated care services, home infusion services, physician oversight, and scheduled team conferences to the procedure codes identified in these instructions and any subsequent updates issued by HCFA. Providers participating in the demonstration must submit claims electronically for demonstration related services with the special processing number 37. Demonstration providers will be instructed by the implementation contractor to submit separate claims for any services not included in the demonstration (usually covered services). Carriers will split claims for services that are not part of the demonstration and apply normal Medicare coverage policy to non-demonstration services.

Services Outside the List of Billable Codes Billed with the Special Processing Number (SPN) 37

Where a provider bills for a service with a date prior to October 1, 2000, with a special processing number of 37, the claim will be rejected by CWF with the appropriate reject message

Exceptions to Carrier's Normal Coverage Policy

Coordinated care services are non-covered by Medicare. Carriers will bypass the non-covered edit only for claims submitted by the CCE that indicates the beneficiary is enrolled in the demonstration.

Electronic Carrier Claims

For the National Standard Format, the special processing number 37 will be in Record/Field EAO-43.0 Special Program Indicator. For ANSI X12 837, the SPN will be in 2-180.C-REF:

REF01 = P4 Project Code
REF02 = Special Processing Number (37)

Intermediary Claims Processing

When you are notified that the CWF is ready to accept MCCD claims, begin processing Medicare claims for dates of service on or after October 1, 2000 based upon these instructions. The implementation contractor will instruct participating providers that only services associated with the demonstration be reported on the claim and to follow all other current billing instructions.

Only those codes identified in this memo are acceptable codes for billing for the coordinated care services.

Intermediaries are required to identify MCCD claims and transmit the special processing number 37 for the CWF to accept these claims. Demonstration outpatient claims (HUOP) will be identified for CWF in field 59, positions 747 and 748.

Exceptions to Intermediary's Normal Coverage Policy

Coordinated care services are non-covered by Medicare. Intermediaries will bypass the non-covered edit only for claims submitted by the demonstration participating providers that indicate the beneficiary is enrolled in the demonstration.

The *effective date* for this Program Memorandum (PM) is October 1, 2000.

The *implementation date* for this PM is October 1, 2000.

Funding will be provided in the contractors' current operating budget.

This PM may be discarded September 30, 2006.

All contractors should address questions or issues surrounding implementation of these instructions to their regional office contact. Regional office contacts should contact Ed Berends at (410) 786-6560 for questions concerning the intermediary or carrier claims processing requirements. The demonstration contact person for this PM is Catherine Jansto at (410) 786-7762. The 837 contact person for this PM is Matt Klischer at (410) 786-7488.

2 Attachments

ATTACHMENT I

Medicare Coordinated Care Demonstration

HCPCS CODE REQUEST FOR SITE ONE (GEORGETOWN)

Code	Description	CWF Edit	Definition
G9001	Coordinated care fee initial rate	Cannot be paid in a month with G9002, G9003, G9004, or G9005	Assessment, supervision, and education of patients with chronic illness requiring complex or multidisciplinary care modalities involving regular monitoring and revision of the plan of care. Includes initial and ongoing assessments, data collection, communication with patient, caregivers, and other providers, integration of new information into the plan of care and/or modification of interventions. Reportable once per month by the coordinated care entity.
G9002	Coordinated care fee maintenance rate	G9001, G9003, G9004, G9005	Ongoing assessment, supervision, and education of patients with chronic illness requiring complex or multidisciplinary care modalities involving periodic monitoring and revision of the plan of care. Includes ongoing assessments, data collection, communication with patient, caregivers, and other providers, integration of new information into the plan of care and/or modification of interventions. Reportable once per month by the coordinated care entity.
G9003	Coordinated care fee risk adjusted high initial	G9001, G9002, G9004, G9005	Assessment, supervision, and education of patients with multiple chronic illnesses requiring complex or multidisciplinary care modalities involving regular monitoring and revision of the plan of care. Includes initial and ongoing assessments, data collection, communication with patient, caregivers, and other providers, integration of new information into the plan of care and/or modification of interventions. Reportable once per month by the coordinated care entity.

G9004	Coordinated care fee risk adjusted low initial	G9001, G9002, G9003, G9005	Assessment, supervision, and education of patients with chronic illness(es) requiring complex or multidisciplinary care modalities involving regular monitoring and revision of the plan of care. Includes initial and ongoing assessments, data collection, communication with other providers, integration of new information into the plan of care and/or modification of interventions. Reportable once per month by the coordinated care entity.
G9005	Coordinated care fee risk adjusted maintenance	G9001, G9002, G9003, G9004	Ongoing assessment, supervision, and education of patients with chronic illness(es) requiring complex or multidisciplinary care modalities involving periodic monitoring and revision of the plan of care. Includes ongoing assessments, data collection, communication with patient and other providers, integration of new information into the plan of care and/or modification of interventions. Reportable once per month by the coordinated care entity.
G9006	Coordinated care home monitoring fee	No restriction	Patient assessment and education regarding monitoring and evaluation of home monitoring device and data collection. Reportable once per month by the coordinated care entity.
G9007	Scheduled Team Conference	Up to two physicians up to two times per calendar year per beneficiary enrolled at any site	Conference by a physician with interdisciplinary team of health professionals or representatives of community agencies or care management entity to coordinate activities of patient care (patient need not be present); approximately 30 to 60 minutes.

G9008	Physician Coordinated Care Oversight Services	Up to two physicians per month per beneficiary enrolled at any site	Physician Coordinated Care Oversight Services include: physician supervision, development and revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies and data, communication (including telephone calls) with other health care professionals involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a 30-day period; 30 to 60 minutes. (patient not present) [Note: This code should not be used unless the beneficiary requires recurrent supervision of therapy. The work involved in providing very low intensity or infrequent supervision services is included in the pre- and post-encounter work of other typically covered physician visits and services.]

ATTACHMENT II

Medicare Coordinated Care Demonstration HCPCS Codes
Definitions to Follow as Sites are Awarded

HCPCS Code	Description	Payable To	CWF Edit cannot be paid in a month with
[1]Gxxx7	Coordinated care fee initial rate	Site 2 only	Gxxx8, Gxxx9, Gxx10, Gxx11
Gxxx8	Coordinated care fee maintenance rate	Site 2 only	Gxxx7, Gxxx9, Gxx10, Gxx11
Gxxx9	Coordinated care fee risk adjusted high initial	Site 2 only	Gxxx7, Gxxx8, Gxx10, Gxx11
Gxx10	Coordinated care fee risk adjusted low initial	Site 2 only	Gxxx7, Gxxx8, Gxxx9, Gxx11
Gxx11	Coordinated care fee risk adjusted maintenance	Site 2 only	Gxxx7, Gxxx8, Gxxx9, Gxx10
Gxx12	Coordinated care home infusion monitoring fee	Site 2 only	No restriction
Gxx13	Coordinated care fee initial rate	Site 3 only	Gxx14, Gxx15, Gxx16, Gxx17
Gxx14	Coordinated care fee maintenance rate	Site 3 only	Gxx13, Gxx15, Gxx16, Gxx17
Gxx15	Coordinated care fee risk adjusted high initial	Site 3 only	Gxx13, Gxx14, Gxx16, Gxx17
Gxx16	Coordinated care fee risk adjusted low initial	Site 3 only	Gxx13, Gxx14, Gxx15, Gxx17
Gxx17	Coordinated care fee risk adjusted maintenance	Site 3 only	Gxx13, Gxx14, Gxx15, Gxx16
Gxx18	Coordinated care home infusion monitoring fee	Site 3 only	No restriction
Gxx19	Coordinated care fee initial rate	Site 4 only	Gxx20, Gxx21, Gxx22, Gxx23
Gxx20	Coordinated care fee maintenance rate	Site 4 only	Gxx19, Gxx21, Gxx22, Gxx23
Gxx21	Coordinated care fee risk adjusted high initial	Site 4 only	Gxx19, Gxx20, Gxx22, Gxx23
Gxx22	Coordinated care fee risk adjusted low initial	Site 4 only	Gxx19, Gxx20, Gxx21, Gxx23

[1]For illustration purposes only. Temporary HCPCS will be assigned at a later date.

Gxx23	Coordinated care fee risk adjusted maintenance	Site 4 only	Gxx19, Gxx20, Gxx21, Gxx22
Gxx24	Coordinated care home infusion monitoring fee	Site 4 only	No restriction
Gxx25	Coordinated care fee initial rate	Site 5 only	Gxx26, Gxx27, Gxx28, Gxx29
Gxx26	Coordinated care fee maintenance rate	Site 5 only	Gxx25, Gxx27, Gxx28, Gxx29
Gxx27	Coordinated care fee risk adjusted high initial	Site 5 only	Gxx25, Gxx26, Gxx28, Gxx29
Gxx28	Coordinated care fee risk adjusted low initial	Site 5 only	Gxx25, Gxx26, Gxx27, Gxx29
Gxx29	Coordinated care fee risk adjusted maintenance	Site 5 only	Gxx25, Gxx26, Gxx27, Gxx28
Gxx30	Coordinated care home infusion monitoring fee	Site 5 only	No restriction
Gxx31	Coordinated care fee initial rate	Site 6 only	Gxx32, Gxx33, Gxx34, Gxx35
Gxx32	Coordinated care fee maintenance rate	Site 6 only	Gxx31, Gxx33, Gxx34, Gxx35
Gxx33	Coordinated care fee risk adjusted high initial	Site 6 only	Gxx31, Gxx32, Gxx34, Gxx35
Gxx34	Coordinated care fee risk adjusted low initial	Site 6 only	Gxx31, Gxx32, Gxx33, Gxx35
Gxx35	Coordinated care fee risk adjusted maintenance	Site 6 only	Gxx31, Gxx32, Gxx33, Gxx34
Gxx36	Coordinated care home infusion monitoring fee	Site 6 only	No restriction
Gxx37	Coordinated care fee initial rate	Site 7 only	Gxx38, Gxx39, Gxx40, Gxx41
Gxx38	Coordinated care fee maintenance rate	Site 7 only	Gxx37, Gxx39, Gxx40, Gxx41
Gxx39	Coordinated care fee risk adjusted high initial	Site 7 only	Gxx37, Gxx38, Gxx40, Gxx41
Gxx40	Coordinated care fee risk adjusted low initial	Site 7 only	Gxx37, Gxx38, Gxx39, Gxx41
Gxx41	Coordinated care fee risk adjusted maintenance	Site 7 only	Gxx37, Gxx38, Gxx39, Gxx40

Gxx42	Coordinated care home infusion monitoring fee	Site 7 only	No restriction
Gxx43	Coordinated care fee initial rate	Site 8 only	Gxx44, Gxx45, Gxx46, Gxx47
Gxx44	Coordinated care fee maintenance rate	Site 8 only	Gxx43, Gxx45, Gxx46, Gxx47
Gxx45	Coordinated care fee risk adjusted high initial	Site 8 only	Gxx43, Gxx44, Gxx46, Gxx47
Gxx46	Coordinated care fee risk adjusted low initial	Site 8 only	Gxx43, Gxx44, Gxx45, Gxx47
Gxx47	Coordinated care fee risk adjusted maintenance	Site 8 only	Gxx43, Gxx44, Gxx45, Gxx46
Gxx48	Coordinated care home infusion monitoring fee	Site 8 only	No restriction
Gxx49	Coordinated care fee initial rate	Site 9 only	Gxx50, Gxx51, Gxx52, Gxx53
Gxx50	Coordinated care fee maintenance rate	Site 9 only	Gxx49, Gxx51, Gxx52, Gxx53
Gxx51	Coordinated care fee risk adjusted high initial	Site 9 only	Gxx49, Gxx50, Gxx52, Gxx53
Gxx52	Coordinated care fee risk adjusted low initial	Site 9 only	Gxx49, Gxx50, Gxx51, Gxx53
Gxx53	Coordinated care fee risk adjusted maintenance	Site 9 only	Gxx49, Gxx50, Gxx51, Gxx52
Gxx54	Coordinated care home infusion monitoring fee	Site 9 only	No restriction