Program Memorandum Intermediaries/Carriers

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal AB-01-30 **Date: FEBRUARY 12, 2001**

CHANGE REQUEST 1548

SUBJECT: Claims Processing Instructions for the Medicare Coordinated Care Demonstration--Correction and Enhancement

This Program Memorandum (PM) amends a previous PM, Change Request 1116, issued as Transmittal. AB-00-71 dated August 7, 2000. The following modifications have been made as part of this Change Request:

- Fourteen (14) additional demonstration sites which will be effective on or after July 1, 2001;
- Four new Level II HCPCS procedure codes for covered demonstration services;
- Instructions for processing unassigned demonstration claims;
- Processing of claims for the fourteen new sites will be done only by the part B system (only Georgetown will continue to be processed by the Part A system);
- Removal of the edit in CWF requiring the provider number on the notice of election (NOE) to match the provider number on the claim;
- Designation of payment amounts for Georgetown demonstration site procedures; and
- Correction of miscellaneous typographical errors relating to codes and form numbers.

This PM clarifies instructions for contractors to use in processing claims received after December 31, 2000, with dates of service January 1, 2001, or later, for the "Georgetown" Medicare Coordinated Care Demonstration (MCCD) site only. In addition, 14 additional demonstration sites will be added on or after July 1, 2001. These instructions shall be implemented by contractors to use in processing claims for all other MCCD demonstration sites on or after July 1, 2001.

Impact Limited to Selected Standard Systems

As reflected in Attachment III, some of the demonstration sites are currently located in areas served by intermediaries and carriers not operating on the Fiscal Intermediary Standard System (FISS) and the Multi-Carrier System (MCS), the selected standard systems. As noted below under "Claims Processing Instructions for Both Intermediaries and Carriers", demonstration sites using intermediaries and carriers not operating on the selected standard systems (FISS and MCS) will not be implemented until those contractors transition to the selected standard systems. Moreover, only the Georgetown site will process demonstration claims through the intermediary. All other demonstration sites will submit all claims for demonstration services to their carrier for processing as Part B claims. This Change Request is NOT requesting any system changes be implemented for any other Part A or Part B systems other than FISS and MCS.

Background

As required by §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. Fifteen Coordinated Care Entities (CCEs) have been selected for the demonstration through a national solicitation. The selected entities will be assigned both Part A and Part B provider numbers if they do not already have them in order to bill for the demonstration services and/or submit notices of election. 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. Beneficiaries will be enrolled through a "NOE" process similar to that used for religious non-medical institutions and hospice care. This NOE will be submitted by the demonstration site to the intermediary.

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. The original demonstration site, Georgetown, was set up such that claims for monthly coordinated care management services were billed through the intermediary and special physician services (see Attachment I) would be billed through the carrier. In order to reduce programming effort, all subsequent sites (see Attachment III) will bill for all services provided under the demonstration through the carrier.

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. 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 was effective January 2001. Fourteen additional sites were selected through a competitive process in 2000 and early 2001.

These sites will begin implementation in July 2001. Operation of the demonstration will continue for 4 years, and, if cost effective, will be extended and possibly expanded.

Enrollment

A 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. A NOE will be submitted to the intermediary by the demonstration site. Therefore, all demonstration sites will be required to be assigned a Part A provider identification number. The intermediary will serve as a conduit and transmit the NOE to the Common Working File (CWF). 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 all of the CCEs but for processing claims for demonstration services performed in an outpatient setting **under the Georgetown demonstration only**.

Appropriate Bill Types

CCEs utilize bill type 89X. 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

CCEs submit a NOE to the intermediary for beneficiary elections made on or after January 1, 2001. This means for MCCD beneficiaries, who are enrolled for participation in the MCCD on or after January 1, 2001, the CCE must submit an election notice to the intermediary for processing.

CCEs 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. CCEs must submit the NOE and receive notification that the election was received prior to billing for demonstration related services.

CWF Notification of Revocations

CCEs 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

CCEs submit a UB-92 flat file (bill type 89X) to the intermediary as a cancellation of a previously submitted NOE 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 89X) 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 NOE by CCEs

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: 89A, 89B or 89D 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.

9 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 January 1, 2001. 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 (HIC) /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

All demonstration sites will be assigned a Medicare participating Part B provider identification number if they do not already have one in order to bill for services under the demonstration. The eight Level II HCPCS codes (G9001-G9008) which have been approved for the Georgetown site will be used by the other demonstration sites as well; however they will only be available for payment under Part B for the sites other than Georgetown. **With the exception of the Georgetown site, no claims will be processed under this demonstration by Part A systems**. The Georgetown site will bill for monthly case management services through the intermediary and other services through the carrier. All other demonstration sites will bill for all services (monthly or otherwise) through the carrier. Payment rates will be unique to each demonstration site and will be determined by provider ID specific rate tables that will be established. Attachment I is a list of those codes already approved for use by the Georgetown site. They will now be available for use by all other demonstration sites billing through Part B systems. Attachment II is a list of those additional HCPCS codes which have been requested. As with the previous codes shown on Attachment I, the type of service for these additional codes will be 1 (TOS = 1). As described above, physicians and other providers will use existing provider identifiers for billing.

Pricing

Because the descriptions of the specific procedure codes may be fairly general (e.g., G9001-coordinated care fee-initial rate), the actual services provided by any one demonstration site may vary from another. As a result, the payment rates for each procedure code identified will be unique to each demonstration site. Provider ID number specific rate tables will be established prior to implementation.

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 through the establishment of a NOE. 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 within the beneficiary's participation period;
- The claims submitted for coordinated care services, physician coordinated care oversight services, and scheduled team conferences 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.

However, CWF should not require that the provider number on either a Part A or Part B claim match the provider number on the NOE. (This is a modification of the original Change Request which was implemented for the Georgetown site effective January, 2001.)

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.

Attachment III shows the intermediaries and carriers with jurisdiction for the new demonstration sites to be added on or after July 1, 2001. Although the intermediaries will be responsible for accepting the NOE, only carriers will be responsible for processing claims for these demonstration sites. Demonstration sites having service areas that cross State lines or otherwise cross contractor jurisdiction, may submit claims to multiple carriers based on the location where the service was provided. Because the NOE process is already operational and no claims will be processed by Part A systems for the new sites, the only requirement for the new demonstration sites that involves the Part A systems will be the assignment of a Part A provider identification number, if one is not already assigned. This does not require any system changes. **Demonstration sites using intermediaries and carriers not operating on the selected standard systems (FISS and MCS) will not be implemented until those contractors transition to the selected standard systems. This Change Request is NOT requesting any system changes be implemented for any other Part A or Part B systems other than FISS and MCS.**

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 Georgetown MCCD from the special condition code "B0" that will be submitted on the claim form by this site. Intermediaries will not be required to process claims from any other demonstration site.

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

All demonstration claims must be submitted by providers as assigned claims. Demonstration claims submitted on an unassigned basis will be processed as assigned claims. Use the remark code MA 09 ("Claim submitted as unassigned but processed as assigned. You agreed to accept assignment for all claims.") to report processing unassigned demonstration claims as assigned.

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 two reasons listed below. 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 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:

English language version:

> "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:

English language version:

> "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

Begin processing Medicare claims for dates of service on or after January 1, 2001, based upon these instructions. Restrict coverage for coordinated care 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 January 1, 2001, 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

Only the Georgetown site will use the intermediary for processing claims. Begin processing Medicare claims for dates of service on or after January 1, 2001, based upon these instructions. The implementation contractor will instruct staff at the Georgetown site 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 PM 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 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 PM is July 1, 2001 (January 1, 2001, for all sections previously incorporated into Change Request 1116, Transmittal AB-00-71).

The *implementation date* for this PM is July 1, 2001. (January 1, 2001, for all sections previously incorporated into Change Request 1116, Transmittal AB-00-71).

These instructions should be implemented within your current operating budget. There are no extra funds allowed for processing claims under this demonstration.

This PM may be discarded July 1, 2007.

All contractors should address questions or issues surrounding implementation of these instructions to their regional office contact. The demonstration contact person for this PM is Cynthia Mason at (410) 786-6680 or Jody Blatt at (410) 786-6921. The 837 contact person for this PM is Matt Klischer at (410) 786-7488.

Attachments 3

ATTACHMENT I

Medicare Coordinated Care Demonstration

HCPCS CODE REQUEST FOR SITE ONE (GEORGETOWN)

Code	Description	CWF Edit	Definition	Payment Amount
G9001	Coordinated care fee-initial rate	Cannot be paid in a month with: G9002, G9003, G9004, G9005, G9009, G9010, G9011	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.	$390 per month for Georgetown; other sites to be determined
G9002	Coordinated care fee-maintenance rate ***(Level 1)***	Cannot be paid in a month with: G9001, G9003, G9004, G9005, G9009, G9010, G9011	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.	$350 per month for Georgetown; other sites to be determined
G9003	Coordinated care fee-risk adjusted high initial	Cannot be paid in a month with: G9001, G9002, G9004, G9005, G9009, G9010, G9011	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.	To be determined-site specific
G9004	Coordinated care fee-risk adjusted low initial	Cannot be paid in a month with: G9001, G9002, G9003, G9005, G9009, G9010, G9011	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.	To be determined-site specific

Code	Description	CWF Edit	Definition	Payment Amount
G9005	Coordinated care fee-risk adjusted maintenance ***(Level 2)***	Cannot be paid in a month with: G9001, G9002, G9003, G9004, G9009, G9010, G9011	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.	To be determined-site specific
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.	To be determined-site specific
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.	$100 for Georgetown; other sites to be determined
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.]	To be determined-site specific

ATTACHMENT II

NEW HCPCS CODES REQUESTED FOR ADDITIONAL MEDICARE COORDINATED CARE DEMONSTRATION SITES

Code 1	Description	CWF Edit	Definition	Payment Amount
G9009	Coordinated care fee-risk adjusted maintenance (***Level 3)***	Cannot be paid in a month with: G9001, G9002, G9003, G9004, G9005, G9010, G9011	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.	To be determined- site specific
G9010	Coordinated care fee-risk adjusted maintenance (***Level 4)***	Cannot be paid in a month with: G9001, G9002, G9003, G9004, G9005, G9009, G9011	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.	To be determined- site specific
G9011	Coordinated care fee-risk adjusted maintenance ***(Level 5)***	Cannot be paid in a month with: G9001, G9002, G9003, G9004, G9005, G9009, G9010	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.	To be determined- site specific
G9012	Other specified case management service not elsewhere classified	No edits	Other service provided by demonstration program for which payment is not otherwise incorporated into monthly case management fee or not specified in another code.	To be determined- site specific

1 The Type of Service for all codes will be "01".

ATTACHMENT III

DEMONSTRATION SITES AND CONTRACTORS USED FOR PROCESSING CLAIMS

Site #	Demonstration Site Name	Service Area	Provider ID *(Demonstration Specific)*	Effective Date	Intermediary*	Part A Processing System*	Carrier*	Part B Processing System*
1	Georgetown	Maryland, DC, Virginia	*TBD*	1/01/01	Care First (BCBS Maryland)	FISS-BCBS Florida	Trailblazers	MCS
The following new sites will be effective after July 1, 2001 and will process claims only through the carrier and Part B processing systems. Intermediaries and Part A processing systems will be responsible for accepting and processing notices of election.								
2	PennCare	Eastern PA	*TBD*	7/1/01	Veritus Medicare Services	FISS	XACT Medicare Services	MCS
3	CanVaNet, Inc	Richmond VA	*TBD*	7/1/01	UGS	FISS	Trailblazers	**HBPSS**
4	QMED, Inc	Northern CA	*TBD*	7/1/01	UGS	FISS	NHIC-California	MCS
							Tolic Transamerica	**VMS**
5	CorSolutions Medical, Inc.	TX	*TBD*	7/1/01	Trailblazers	FISS	Trailblazers	MCS
		IN	*TBD*	7/1/01	Anthem	FISS	AdminaStar	**VMS**
6	Hospice of the Valley	Maricopa County, AZ	*TBD*	7/1/01	BCBS Arizona	FISS	Noridian Mutual	**GTEMS**
7	WA University & Status One Health	St.Louis, MO	*TBD*	7/1/01	Mississippi BC	FISS	BCBS Arkansas	**GTEMS**
							BCBS Kansas	**VMS**
8	University of MD	Baltimore, MD	*TBD*	7/1/01	Care First (BCBS Maryland)	FISS-BCBS Florida	Trailblazers	MCS
9	The Jewish Home & Hospital	New York, NY	*TBD*	7/1/01	Empire BCBS	FISS	Empire BCBS	**VMS**

*** Demonstration sites using intermediaries and carriers that are not operating on the selected standard processing systems (i.e. FISS for Part A and MCS for Part B) will be implemented *only after* the contractor has transitioned to these selected standard systems. NO PROGRAMMING CHANGES ARE BEING REQUESTED FOR SYSTEMS OTHER THAN FISS OR MCS.**

10	Quality Oncology, Inc.	Broward County, FL	*TBD*	7/1/01	BCBS Florida	FISS	BCBS Florida	**GTEMS**
11	Erickson Retirement Community, Inc.	Baltimore, MD	*TBD*	7/1/01	Care First (BCBS Maryland)	FISS	Trailblazers	MCS
12	Carle Foundation Hospital	Eastern IL	*TBD*	7/1/01	Anthem	FISS	Wisconsin Physician Services	MCS
13	Avera McKennan Hospital	SD	*TBD*	7/1/01	BCBS Alabama	FISS	Noridian Mutual	MCS
		IA	*TBD*	7/1/01	BCBS Alabama	FISS	Noridian Mutual	MCS
		MN	*TBD*	7/1/01	Noridian	FISS	Wisconsin Physician Services	**HBPSS**
14	Medical Care Development	ME	*TBD*	7/1/01	Associated Hospital Services of Maine	**APASS-BCBS Arkansas**	NHIC-New England	MCS
15	Mercy Medical Center	Northern IA	*TBD*	7/1/01	BCBS Alabama	FISS	Noridian Mutual	MCS