CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-19 Demonstrations	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 58	**Date: JUNE 27, 2008**
	Change Request 6001

Subject: Medicare Acute Care Episode Demonstration - Rescinds and fully replaces CR 5767

I. SUMMARY OF CHANGES: Rescinds and replaces CR 5767. The only change is specifying the geographic location of the demonstration is A/B MAC Jurisdiction 4 (Texas, Oklahoma, Colorado, and New Mexico).

New / Revised Material
Effective Date: For admissions occurring on or after January 1, 2009

Implementation Date: January 1, 2009 is the implementation date for demonstration. The CR may be split over several releases to accommodate resource requirements and availability however all coding and testing must be complete and systems ready to go on January 1, 2009. MCS, FISS, CWF and applicable MAC(s) must coordinate to meeting this timeline.

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:
SECTION A: For Fiscal Intermediaries and Carriers:
Not Applicable.

SECTION B: For Medicare Administrative Contractors (MACs):

This CR applies only to the MAC in MAC Jurisdiction 4 which covers the States Texas, Oklahoma, New Mexico, and Colorado.

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.

It has been determined that this CR requires funding for activities outside the regular CR process. This has been arranged internally at CMS.

IV. ATTACHMENTS:

One-Time Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – One-Time Notification

Pub. 100-19	Transmittal: 58	Date: June 27, 2008	Change Request: 6001

SUBJECT: Medicare Acute Care Episode Demonstration - Rescinds and fully replaces CR 5767

IMPORTANT NOTE: Many of the changes specified under this notification were previously outlined for other demonstrations (Centers of Excellence, Provider Partnerships, Virginia Cardiac Surgery Quality Initiative) in the transmittals indicated under Section IV, Supporting Information. As a result, most of the standard system (FISS, MCS, CWF) changes necessary to implement this demonstration may already be in place and minimal additional modifications may be required.

Effective Date: For admissions occurring on or after January 1, 2009.

Implementation Date: January 1, 2009 is the implementation date for demonstration. The CR may be split over several releases to accommodate resource requirements and availability however all coding and testing must be complete and systems ready to go on January 1, 2009. MCS, FISS, CWF and applicable MAC(s) must coordinate to meeting this timeline.

Implementation Area: The ACE demonstration will accept applications from qualified providers in MAC Jurisdiction 4 only. This includes Texas, Oklahoma, New Mexico, and Colorado.

I. GENERAL INFORMATION

A. Background:

As a value based purchaser of care, the Centers for Medicare and Medicaid Services (CMS) seeks to devise and test new methods of paying providers that will encourage improvements in both the efficiency and quality of care provided to Medicare beneficiaries. The Acute Care Episode (ACE) Demonstration is specifically designed to align incentives and provide flexibility to hospitals and physicians by bundling all related services into an "episode of care" and paying a single, global payment that can be used as the providers of care deem most appropriate. Approximately 15 demonstration sites will be selected to participate in this demonstration which is currently projected to start on or after January 1, 2009. Sites will be selected from among states that pay claims under the diagnostic related group (DRG) inpatient prospective payment system. Individual demonstration projects sites will continue for three years from their first date of operation, although CMS will have the option to extend them and/or add additional demonstration sites.

This One Time Notification contains claims processing instructions and the standard system and CWF changes required for contractors to process and pay for acute inpatient episodes of care under this demonstration. Although all of the demonstration sites will not necessarily commence operations under the demonstration on the same date, systems shall be operational to process claims under this demonstration with dates of admission on or after January 1, 2009.

B. **Policy:**

The goal of the demonstration is to align hospitals' and physicians' incentives to work together to provide coordinated, cost effective care, thus achieving savings to the Medicare program and giving hospitals and physicians the flexibility to allocate resources as they determine is the most appropriate. All proposals will be thoroughly reviewed by a technical expert panel to insure the organizational capacity to carry out the demonstration. Participating entities will be required to submit quality data relevant to the services being provided under the demonstration.

Entities may submit proposals for a global payment under the demonstration for one or more of the categories listed in Attachment II. However, if a demonstration site is selected for a particular category of DRGs, all admissions for eligible beneficiaries to the facility for DRGs in that category shall be processed under the demonstration payment rules. CMS staff shall provide contractors with a list of all demonstration providers and their associated identification numbers (e.g. NPI, Medicare legacy provider identification number, etc) as well as DRGs covered under the demonstration for each facility.[1]

Under this demonstration, it is intended that the cost reports and settlement for disproportionate share and indirect medical education be processed based on what the A/B MAC would have paid for Part A services in the absence of the demonstration.

A more complete summary of the demonstration design and how it relates to the required system changes is included in Attachment 1.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement.

Number	Requirement	A/B MAC	DME MAC	RHHI	Shared-System Maintainers				OTHER
					FISS	MCS	VMS	CWF	
	GENERAL REQUIREMENTS								
6001.1	CMS staff shall provide all contractors and standard system maintainers with a list of hospitals participating in the demonstration, their Medicare identification numbers (legacy and NPI), the DRGs that shall be covered at that hospital under the demonstration, and a contact person at each hospital. If necessary, this information may be updated by CMS staff during the course of the	X			X	X		X	CMS Staff

[1] Although this information is expected to be relatively static and stable during the course of the demonstration, there is the possibility of it requiring infrequent updates during the course of the demonstration. Therefore, the systems specifications should allow for updates that minimize new coding.

Number	Requirement	A/B MAC	DME MAC	RHHI	Shared-System Maintainers				OTHER
					FISS	MCS	VMS	CWF	
	demonstration.								
6001.2	All claims submitted by hospitals for payment under this demonstration shall be validated against this list of participating demonstration providers and covered demonstration DRGs.				X			X	
	DETERMINATION OF PAYMENT RATES UNDER THE DEMONSTRATION								
6001.3	CMS staff shall be responsible for negotiating bundled payment rates to cover all Part A & Part B services for a given DRG at each participating demonstration hospital. These rates shall be specific to each hospital and DRG.								CMS Staff
6001.4	The bundled payment shall be processed by the A/B MAC serving the demonstration hospital.	X			X				
6001.5	CMS staff shall provide contractors and standard system maintainers with a file with hospital and DRG specific rates for all hospitals participating in the demonstration at least 60 days prior to the effective date of any rate. The format for this file shall be determined jointly by CMS and the standard system maintainer. Rates may be subject to update on a periodic basis. While most rate updates shall be annual, effective in October with other DRG payment updates for the coming fiscal year, rate updates may be effective at other times.	X			X				CMS Staff
6001.6	In addition to the global payment amount, CMS will calculate a fixed Part B copayment (in lieu of a variable Part B coinsurance) applicable to each covered DRG code grouping as appropriate. This Part B copayment will be unique for each hospital and DRG regardless of actual services rendered to an individual beneficiary. The calculated amounts will be provided to the	X			X				CMS Staff

Number	Requirement	A/B MAC	DME MAC	RHHI	Shared-System Maintainers				OTHER
					FISS	MCS	VMS	CWF	
	applicable A/B MACs by CMS. No Part B deductible will be applied to demonstration claims.								
	NOTICE OF ADMISSION PROCESSING								
6001.7	Demonstration hospitals shall submit a "Notice of Admission (NOA)" using Direct Data Entry (DDE) whenever: (1) a beneficiary to be covered under the demonstration(s) is admitted (or as soon thereafter as possible); or (2) if the patient's demonstration status (i.e., covered or not covered under the demonstration) changes. The proposed standardized NOA will take advantage of the same "notice of election" process used to elect hospice benefits and receive services by a religious non-medical health care facility.	X						X	Demo hospital
6001.7.1	If an error is made on an NOA, the hospital shall be required to cancel the original NOA and submit a new NOA. Hospitals must submit the NOA using direct data entry (DDE) and receive verification that the election was received and accepted by CWF prior to billing for demonstration related services.	X						X	Demo hospital
6001.8	Demonstration hospitals shall not submit a separate NOA when a patient is discharged and the admission period ends.	X							Demonstration hospitals
6001.8.1	The discharge date from the final discharge bill will be put on the auxiliary record created from the NOA by CWF thereby "revoking" it when the patient is discharged.	X						X	
6001.9	Hospitals are required to complete all of the standard information normally required on an NOA. Attachment V lists the required fields.	X			X			X	Demonstration Hospital
6001.9.1	In addition to the legacy Medicare Provider Identification Number, the system shall record and transmit on the NOA the National Provider Identifier (NPI).	X			X			X	Demonstration Hospital

Number	Requirement	A/B MAC	DME MAC	RHHI	Shared-System Maintainers				OTHER
					FISS	MCS	VMS	CWF	
	However, in accordance with standard processing guidelines, the NPI shall be mapped to the traditional Medicare Provider Identification number for processing.								
6001.9.2	In addition to the standard required fields, the hospital shall also submit the following information on the NOA: <u>FL 63. Treatment Authorization Code field</u>- This field shall be used to record the demonstration number ("54").	X			X			X	Demonstration Hospital
6001.10	The NOA shall be created and submitted via direct data entry. However, the hospital shall maintain the original, signed notice of admission, which shall be available for review, if necessary.	X			X				Demo hospital
6001.11	Upon receipt of the NOA from the hospital, the standard system shall check to determine whether the NOA is for a demonstration hospital, AND that the NOA includes the appropriate demonstration number.	X			X				
6001.12	If the NOA is from a provider that is not a demonstration hospital, then contractors shall reject the NOA and send a remittance advice with the appropriate reason to the hospital.	X			X				
6001.13	If the provider is a demonstration hospital and did not report the appropriate demonstration number, then the system shall return the NOA to the hospital requesting that the hospital resubmit an NOA with the complete, correct information.	X			X				
6001.14	If the NOA is for a demonstration hospital and the correct demonstration number is reported, the standard system shall transmit the NOA to the CWF.	X			X				
6001.14.1	The A/B MAC shall also be responsible for transmitting all notices to the hospital as directed by the CWF.	X							
6001.15	Upon receipt of the NOA, CWF shall check whether an NOA already exists in the auxiliary							X	

Number	Requirement	A/B MAC	DME MAC	RHHI	Shared-System Maintainers				OTHER
					FISS	MCS	VMS	CWF	
	record file set up to store NOAs. If this is a new NOA, CWF will edit the NOA to determine whether the beneficiary is eligible for the demonstration. The following eligibility requirements will be verified: • Beneficiary is eligible for Part A and enrolled in Part B; • Beneficiary has at least one lifetime reserve day on the date of admission; • Beneficiary is not enrolled in any managed care plan (Medicare Advantage, HCPP, cost-based HMO, or any other similar plan)[2]; • Beneficiary must not be covered under Railroad Retirement Board or United Mine Workers; and • Medicare must be the primary payer. Working aged/disabled beneficiaries with health insurance coverage through their own or a spouses employer group plan are not eligible to participate in the demonstration if that plan is primary. Individuals eligible for Medicare on the basis of ESRD for whom a GHP is primary to Medicare during the 30-month coordination period are not eligible to participate. Beneficiaries with an MSP indicator of auto liability or workers compensation or other MSP indicator shall be eligible to participate in the demonstration as long as Medicare would be the primary payer for all services covered in the demonstration.								
6001.16	If any of the above beneficiary eligibility conditions are not met, CWF shall reject the NOA and notify the A/B MAC to return the	X			X			X	

[2] In some cases, contractors process inpatient claims for beneficiaries enrolled in a Medicare managed care plan. These may be claims for indirect medical education (IME) or the full admission. These claims should continue to be processed as they are currently. Beneficiaries enrolled in any type of Medicare health plan are not eligible for the demonstration, even if all or a portion of the claim is processed using Medicare fee-for service claims processing systems.

Number	Requirement	A/B MAC	DME MAC	RHHI	Shared-System Maintainers				OTHER
					FISS	MCS	VMS	CWF	
	NOA to the hospital.								
6001.17	If the eligibility requirements noted above are all met, CWF shall set up a record in an auxiliary file with the relevant information and notify the A/B MAC that the NOA has been accepted.							X	
6001.17.1	The A/B MAC shall then send the appropriate acknowledgement to the hospital confirming the action.	X							
6001.18	If this is not a new NOA (i.e. a similar NOA for the same beneficiary and dates exists), CWF shall check to see if it is a cancellation of an existing NOA (e.g., in the case where a patient was originally expected to be covered under a demonstration DRG but due to a change in clinical situation is now expected to be discharged under a different, non-demonstration DRG). If so, CWF shall cancel the NOA.							X	
6001.18.1	The A/B MAC shall notify the hospital confirming that the NOA has been cancelled.	X							
6001.19	In all cases, CWF shall notify the A/B MAC of any actions taken pertaining to the NOA.	X						X	
6001.19.1	In turn, the A/B MAC shall notify the hospital of any and all actions to the NOA.	X							
6001.19.2	Hospitals shall be able to review NOAs as a group without having to look up each beneficiary individually by HIC# to determine whether the NOA related transaction was processed as requested.	X			X			X	Demo hospitals
6001.20	If the NOA is not a new NOA but it also does not cancel the matching NOA, then CWF shall reject the NOA back to the A/B MAC as a “duplicate”.	X			X			X	
	FINAL DISCHARGE BILLING BY THE HOSPITAL								
6001.21	All demonstration hospitals shall be required to bill electronically using any Medicare approved standard formats.								Demo hospitals
6001.22	In order to participate in the demonstration, hospitals shall be required to participate in CMS’s hospital quality reporting initiatives.	X			X				Demo hospitals
6001.23	Hospitals shall submit the demonstration								Demo hospitals

Number	Requirement	A/B MAC	DME MAC	RHHI	Shared-System Maintainers FISS	MCS	VMS	CWF	OTHER
	special processing number on all claims to be processed under the demonstration and as described in this change request. Only inpatient hospital claims shall be eligible for processing under the demonstration global payment. The demonstration special processing number is "54".								
6001.24	Hospitals shall submit condition code "B1" if the claim is for a DRG that is covered under the demonstration, but due to beneficiary eligibility or other reasons, the claim shall not to be processed as a demonstration claim. Condition Code B1: *Beneficiary Ineligible for Demonstration Program", has been approved by the National Uniform Billing Committee to be used for these demonstrations effective 10/1/2001.* The intent of this condition code is to allow for timely and efficient fee-for-service processing when the hospital knows in advance that the beneficiary is not eligible for coverage under the demonstration, and the claim should be processed in the traditional fee-for-service manner (e.g., if Medicare is a secondary payer or the beneficiary does not have Part B).				X			X	Demo hospitals
6001.25	Final bills for demonstration patients will not be paid unless there is a matching NOA on file.	X			X			X	
6001.26	Upon receipt of the final discharge bill from the demonstration hospital, the A/B MAC and/or standard system shall make several "edit checks" in order to determine whether this is a demonstration claim.	X			X			X	
6001.26.1	First, the system shall check whether the hospital's provider number matches the list of hospitals participating in the demonstration. If it is not a demonstration provider, traditional fee for service (FFS) processing rules will be	X			X				

Number	Requirement	A/B MAC	DME MAC	RHHI	Shared-System Maintainers				OTHER
					FISS	MCS	VMS	CWF	
	followed.								
6001.26.2	If the hospital submitting the claim is a demonstration provider, a second check shall be made. The standard system shall look to see if there is a demonstration number on the claim.	X			X				
6001.26.3	If there is no demonstration number on the claim, the standard system shall check to determine whether a special condition code ('B1') is on the bill submitted by the hospital to indicate that the claim should not be processed as a demonstration claim even though it may be for a covered procedure.	X			X				
6001.26.4	If there is the special condition code 'B1' on the claim, the standard system shall transmit the claim to CWF to check whether there is a matching NOA on file for this admission. A matching NOA is one where the billing hospital provider number, beneficiary HIC number and date of admission on the NOA and the claim are the same.	X			X			X	
6001.26.5	If there is the special condition code 'B1' on the claim and if there is an open NOA on file, CWF shall reject the claim. The claim shall be returned to the hospital which shall be instructed to cancel the NOA before submitting the final discharge bill.	X			X			X	Demo hospital
6001.26.6	If there is the special condition code 'B1' on the claim and if there is no NOA on file (or only a cancelled NOA), CWF and the standard systems shall proceed with traditional fee for service processing of the claim.	X			X			X	
6001.27	CWF will create a new edit to indicate if the provider ID of the hospital billing for the global payment does not match the provider number of the hospital on the notice of admission.	X			X			X	
6001.27.1	If the provider ID of the hospital billing for the global payment does not match the provider number of the hospital on the NOA, CWF shall reject the claim back to the A/B MAC which shall, in turn, return the claim to the hospital, instructing them to either re-submit the bill without the demonstration code or cancel the	X			X			X	Demo Hospital

Number	Requirement	A/B MAC	DME MAC	RHHI	Shared-System Maintainers				OTHER
					FISS	MCS	VMS	CWF	
	NOA (as appropriate) before submitting the final discharge bill.								
6001.28	Demonstration inpatient claims will be identified for CWF by a “54” in the Demonstration Number field on the transmit record to CWF. The precise fields and positions are subject to change if at the time of implementing this CR, new fields have been added to the record layout, thereby changing the appropriate field number and position.	X			X			X	
6001.29	All demonstration claims shall be processed by the Inpatient pricing system and assigned a DRG.	X			X				
6001.30	If the demonstration number is on the claim the standard system maintainer will check to see if the DRG for the claim is covered under the demonstration for that hospital				X				
6001.30.1	If the DRG is not covered under the demonstration, the claim shall be returned to the hospital for correction , and the hospital shall re-bill without the demonstration number.	X			X				
6001.31	If there is *neither* a *demonstration number (54) nor a special condition code (B1)* on the claim, the standard system maintainer shall check to see if the DRG for the claim is covered under the demonstration for that hospital.	X			X				
6001.31.1	If the DRG is not covered under the demonstration for that hospital, the claim will be processed as a traditional fee-for-service Part A claim.	X			X			X	
6001.32	Because an NOA may have been set up under the expectation that the discharge DRG would be one covered under the demonstration, CWF shall always check for a matching open NOA when a demonstration provider submits a claim without a demonstration number.							X	
6001.32.1	If an NOA is found but the DRG is not one covered under the demonstration, the claim shall be returned to the hospital. The hospital will be instructed to cancel the NOA before re-submitting the bill.	X			X			X	

Number	Requirement	A/B MAC	DME MAC	RHHI	Shared-System Maintainers				OTHER
					FISS	MCS	VMS	CWF	
6001.32.2	If the DRG on the claim is not one covered under the demonstration and there is no corresponding open NOA, then traditional FFS Medicare processing rules will be followed.	X			X			X	
6001.33	If the DRG is covered under the demonstration, the standard system maintainer shall confirm that the procedure / diagnosis is also covered under the demonstration (e.g., Under the demonstration some procedures within a given DRG may be excluded from the demonstration).	X			X				
6001.33.1	If the procedure/diagnosis is not covered under the demonstration for the hospital AND there is a demonstration number (54) on the claim, the claim shall be returned to the hospital for re-billing without the demonstration number.	X			X				
6001.33.2	If the procedure/diagnosis is not covered under the demonstration AND there is *no demonstration number on the claim*, it will be processed as a traditional fee-for-service Part A claim.	X			X				
6001.34	If the DRG and procedure/diagnosis are covered under the demonstration and there is a demonstration number on the claim, the standard system shall check to see if, based on the claim, the patient is being discharged to another inpatient facility. *(Both acute care and post acute care shall be considered when reviewing "transfers". See Attachment I, "Design Summary"- "Special Circumstances" under "Transfers".)*	X			X				
6001.34.1	If the DRG and procedure/diagnosis are covered under the demonstration, there is a demonstration number on the claim, and the patient is being discharged to another inpatient acute care facility, the system shall also check to see whether the length of stay would warrant a full DRG payment for the given DRG.	X			X				
6001.34.2	If the patient is being transferred and the length of stay is short enough such that a per diem payment less than the full DRG would be paid to the hospital, the claim shall be returned to the hospital and the hospital shall be instructed	X			X				

Number	Requirement	A/B MAC	DME MAC	RHHI	Shared-System Maintainers				OTHER
					FISS	MCS	VMS	CWF	
	to re-bill with the appropriate condition code and without the demonstration number. That is, that patient will not be assigned to the demonstration.								
6001.34.3	If the patient is not being transferred or, if transferred, the length of stay is long enough to warrant a full DRG payment, the claim will be transmitted to CWF.	X			X				
6001.35	If the DRG and procedure are covered under the demonstration, but neither the demonstration number nor the special condition code are on the claim, the claim shall be returned to the hospital and the hospital shall be instructed to re-bill with either the demonstration number or the condition code on the bill to indicate how it should be paid.	X			X				
6001.36	Upon receipt of a demonstration claim from the A/B MAC that meets other requirements, CWF shall check to determine if there is an auxiliary record (i.e. an NOA) on file corresponding to the claim.	X						X	Demo hospital
6001.36.1	If there is no NOA on file, CWF shall reject the claim back to the A/B MAC. The A/B MAC shall return the bill to the hospital with instructions to re-bill with the appropriate condition code and without the demonstration number or, if this should be a demonstration claim, set up the NOA prior to billing.	X			X			X	
6001.36.2	If there is an NOA for this admission on file, CWF will check to see if the provider number on the NOA matches the provider number on the claim. If they do not match, CWF shall reject the claim back to the A/B MAC. The A/B MAC shall return the bill to the hospital with instructions to re-bill with the correct provider number or without the demonstration number, or correct the NOA, as appropriate.	X			X			X	
6001.36.3	If there is an NOA on file and the provider number on the NOA matches the provider number on the claim, CWF shall "revoke" the NOA by putting the discharge date on the NOA in the auxiliary record.							X	

Number	Requirement	A/B MAC	DME MAC	RHHI	Shared-System Maintainers				OTHER
					FISS	MCS	VMS	CWF	
6001.37	If the claim has not been rejected, after the CWF has put the discharge date on the NOA, CWF shall send a response back to the A/B MAC with authorization to pay the global payment.	X			X			X	
6001.38	CWF shall send all claims processed under the demonstration to the national claims history file.							X	
6001.39	After processing by the CWF, the claim shall come back to the A/B MAC for final processing. If the claim is to be paid under the demonstration, the A/B MAC shall be responsible for processing the global payment and sending demonstration specific remittance advice statements and Medicare Summary Notices (MSNs) to hospitals and beneficiaries, respectively.	X			X				
6001.40	A remittance advice shall be sent by the A/B MAC to the hospital for each claim paid under the demonstration. The remittance advice will show the total global payment allowed under the demonstration including any portion of the global payment attributable to the interim payment for indirect medical education or disproportionate share. In addition, patient liabilities for the Part A deductible and coinsurance and/or the appropriate fixed Part B copayment that will be applied under the demonstration shall also be shown on the remittance advice.	X			X				
6001.41	Crossover claims ((i.e., claims where there is a Medigap insurer that will pick up some of the patient payments) should continue to be processed in the same manner as they are under traditional processing.	X			X			X	
6001.41.1	CMS staff shall undertake efforts to educate Medigap insurers about the demonstration.								CMS Staff
6001.42	FIs and A/B MACs must continue to report any regular Part A coinsurance for a demonstration claim (with claim adjustment group PR and reason code 2) in the remittance advice. Coinsurance attributable to the Part B services that previously would have been paid by the FIs	X			X				

Number	Requirement	A/B MAC	DME MAC	RHHI	Shared-System Maintainers				OTHER
					FISS	MCS	VMS	CWF	
	and/or A/B MACs for professional claims must be reported using group PR and claim adjustment reason code 3 (copayment amount) with remark code M137 (Part B coinsurance under a global payment demonstration) at the claim level. PR signifies that the patient (or his/her other supplemental payer) is responsible for payment of this amount. Under the demonstrations, the facility must collect both types of coinsurance from the beneficiary or the beneficiary's supplemental payer. We must differentiate between the types of patient liabilities for Medicare accounting purposes.								
6001.43	For bills submitted to CWF, the FIs and A/B MACs will report the negotiated payment amount less any deductible or coinsurance amounts applicable, i.e., the amount paid to the provider, in the reimbursement field of the claims record. The A/B MAC processing the institutional claim will compute what the applicable inpatient payment would have been under the traditional Medicare fee-for-service program, and other payment amounts in the value code area of the claims record as shown below. <u>Y1 Part A Demonstration Payment-</u> This is the portion of the payment designated as reimbursement for Part A services under the demonstration. This amount is instead of the traditional prospective DRG payment (operating and capital) as well as any outlier payments that might have been applicable in the absence of the demonstration. No deductible or coinsurance has been applied. Payments for operating IME and DSH which are processed in the traditional manner are also not included <u>Y2 Part B Demonstration Payment</u>	X			X			X	

Number	Requirement	A/B MAC	DME MAC	RHHI	Shared-System Maintainers FISS	MCS	VMS	CWF	OTHER
	This is the portion of the payment designated as reimbursement for Part B services under the demonstration. No deductible or coinsurance has been applied. <u>Y3 Part B Coinsurance</u> This is the amount of Part B coinsurance applied by the A/B MAC to this claim. For demonstration claims this will be a fixed copayment unique to each hospital and DRG (or DRG/procedure group) <u>Y4 Conventional Provider Payment Amount for Non-Demonstration Claims</u> This is the amount Medicare would have reimbursed the provider for Part A services if there had been no demonstration. This should include the prospective DRG payment (both capital as well as operational) as well as any outlier payment, which would be applicable. It does not include any pass through amounts such as that for direct medical education nor interim payments for operational IME or DSH The actual payment to the hospital under the demonstration shall be equal to the dollar amounts represented by: <u>*"Y1" + "Y2" + Operational IME + Operational DSH minus the Part A deductible and any Part A coinsurance that might be applicable and minus "Y3", the Part B coinsurance*</u>.								
6001.44	Information regarding what would have been paid in the absence of a demonstration is not required to be put on the remittance advice sent to hospitals.	X			X				
6001.45	However, monthly reports showing what was paid and what would have been paid under Part A shall be produced sent to the hospital.	X			X				

Number	Requirement	A/B MAC	DME MAC	RHHI	Shared-System Maintainers FISS	MCS	VMS	CWF	OTHER
	These reports are separate from the weekly reports that will be produced showing no pay demonstration claims processed under Part B and what would have been paid in the absence of the demonstration. (See below and Attachment IV.)								
6001.46	The standard system shall compute and apply the applicable Part A deductible and coinsurance amounts and apply the DRG-specific fixed Part B copayment (which CMS will calculate in lieu of the traditional coinsurance) amount. The Part A blood deductible shall be applied as usual. The Part B blood deductible shall be waived as there is no Part B deductible applied for this demonstration.				X			X	
6001.47	The Medicare Summary Notice (MSN) shall contain the beneficiary's total liability including Part A deductible, Part A coinsurance, Part B coinsurance (the fixed copayment), and Part A blood deductible, if applicable.	X			X				
6001.47.1	The MSN shall contain the following statements:	X			X				

Paragraph #	MSN Message #	MSN Text- English	MSN Text - Spanish
1	60.1	(Name of Hospital), in partnership with physicians in your area, is participating in a Medicare demonstration project that uses a simplified payment method to combine all hospital and physician care related to your hospital service	(Name of Hospital) en cooperación con médicos en su área, están participando en una demostración de Medicare el cual utiliza un método de pago simplificado que combina todos los hospitales y médicos relacionados a sus servicios de hospital. Este pago sencillo va a hacer el proceso de facturación más fácil mientras que mantiene el costo más bajo o al mismo nivel de como era bajo el sistema tradicional de pago.

2	32.2	You should not be billed separately by your physician(s) for services provided during this inpatient stay	Usted no debe ser facturado separadamente por su(s) medico(s) por los servicios brindados durante esta hospitalización.
3	60.2	The total Medicare approved amount for your hospital service is $ ____________. $___________ is the Part A Medicare amount for hospital services and $___________ is the Part B Medicare amount for physician services (of which Medicare pays 80 %). You are responsible for any deductible and coinsurance amounts represented.	La cantidad total que Medicare aprobó por sus servicios de hospital es de $__________. $___________ es la cantidad de Medicare Parte A por sus servicios de hospital y $_________ es la cantidad de Medicare Parte B por sus servicios médicos (de los cuales Medicare paga el 80%). Usted es responsable por cualquier deducible y coseguro presentado más abajo.
4	60.3	Medicare has paid $ __________for hospital and physician services. Your Part A deductible is $_________. Your Part A blood deductible is $_____. Your Part A coinsurance is $_________. Your Part B coinsurance is $_________.	Medicare pagó $_________por servicios de hospital y por servicios médicos. Su deducible de la Parte A es $__________. Su deducible de la Parte A para sangre es $__________. Su coseguro de la Parte A es $__________. Su coseguro de la Parte B es $__________.

Number	Requirement	A/B MAC	DME MAC	RHHI	Shared-System Maintainers: FISS	MCS	VMS	CWF	OTHER
6001.48	All applicable, routine edits will be applied to demonstration claims. The only EXCEPTION to this will be the bypassing of edits for post acute care (PAC) transfers.	X			X				
6001.49	Normal activities for audit, medical review, MSP and fraud and abuse shall be required for demonstration claims.	X			X	X		X	
6001.50	For Medicare cost reporting purposes; demonstration patients will be treated as Medicare patients. Under this demonstration, it is intended that the cost reports and settlement for disproportionate share and indirect medical education be processed based on what the A/B MAC would have paid for Part A services in the absence of the demonstration.	X							PS&R
6001.51	Demonstration claims shall be counted as part of the normal monthly workload.	X			X				

Number	Requirement	A/B MAC	DME MAC	RHHI	Shared-System Maintainers				OTHER
					FISS	MCS	VMS	CWF	
6001.52	Because IME and DSH payments shall be processed in the same manner as for non-demonstration claims, they shall be included in calculations of payment accuracy by the A/B MAC.	X			X				
6001.53	Interest shall be paid on the Part A portion of the claim to the extent it would otherwise have been paid to the hospital in the absence of the demonstration.	X			X				
6001.54	The same rules regarding payment of readmissions to a hospital under the traditional Medicare Fee For Service program shall apply to claims processed under the demonstration. Thus, if the admission would be considered part of the original admission for purposes of payment (i.e., a second DRG payment would not be made), then it would also be considered to be covered under the first global DRG payment. If the second admission would be considered a new admission for purposes of payment, then a second global payment shall also be made. Similarly, if pre-admission services at a hospital would be covered under the traditional Part A inpatient DRG payment, then they shall also considered part of the global payment and not be separately paid	X			X			X	
6001.54.1	If the admission is considered part of the original admission for purposes of payment, then the hospital will not get a second global payment. However, demonstration hospitals shall be required to submit a new NOA to cover the re-admission.	X			X			X	Demo Hospitals
6001.55	The global payment includes an adjustment for outliers. No separate payment for outliers should be processed.	X			X				
6001.55.1	Payment shall not be made based on Value Code "17". However, the amount that would have been paid for outliers must be calculated and recorded on the claim record in order to be available for reporting.	X			X				

Number	Requirement	A/B MAC	DME MAC	RHHI	Shared-System Maintainers				OTHER
					FISS	MCS	VMS	CWF	
6001.56	New technology add-on payments shall be made to demonstration hospitals in addition to the global payment to the same extent the hospital would have received those payments in the absence of the demonstration.	X			X				
6001.56.1	The remittance advice sent to the demonstration hospital shall explicitly list any additional reimbursement due to new technology or , hemophelia, add ons that shall be paid in addition to the global payment.	X			X				
	PROCESSING PHYSICIAN[3] AND OTHER PART B CLAIMS FOR SERVICES TO INPATIENT BENEFICIARIES UNDER THE GLOBAL PAYMENT								
6001.57	Physicians and other professional providers shall be requested but not required to submit claims electronically, unless otherwise required by Medicare.	X							Physicians
6001.58	Physicians and other professional providers shall not be required to submit claims with the demonstration code number on them.	X							Physicians
6001.59	If required, as described below, physicians shall submit the site of service provider NPI on a claim.								Physicians
6001.59.1	If a physician performs a service(s) in a hospital (Place of Service Codes = 21, 22, or 23) or independent laboratory (Place of Service code = 81) for a patient who is an inpatient, the physician should put the NPI of the hospital where the patient was located, in addition to name and address. The NPI should be put in item 32 on the claim form. Providers are permitted to bill only one site of service provider number per claim. For Electronic Claims: ANSI X 12N 837 (version 4010A1) - Report the name of the hospital/facility in loop 2310D								Physicians

[3] For simplicity, all future reference in this document will be to "physician" claims. However, this would include all other Medicare covered Part B professional claims from, for example, dentists, therapists, etc.

Number	Requirement	A/B MAC	DME MAC	RHHI	Shared-System Maintainers FISS	MCS	VMS	CWF	OTHER
	– Service Facility Location. 2 Report the hospital/facility address in loop 2310-D-Service Facility Location Address..								
6001.60	Nothing in this notification is intended to contradict previously or subsequently issued requirements which require physicians to submit other claims for hospital-located services with the appropriate Service Facility Location NPI.	X				X		X	Physicians
6001.61	This change request requires that the site of service provider ID (NPI) be transferred to the Common Working File in order to accomplish the edits described. When sending a Service Facility *(Note, the 837(P) term is "Service Facility Location" (2310D NM Segment)* Location NPI to CWF, A/B MACs shall send the Service Facility Location NPI to CWF on the HUBC. At the time the requirements in CWF are created, the precise location of this field will be identified.	X				X		X	
6001.62	CWF shall map the site of service NPI to the legacy provider identification number. This number shall then be matched to the list of demonstration providers (See business requirement #1.) in order to determine, as described below, whether the services rendered by a physician were provided at a demonstration hospital.							X	
6001.62.1	CWF shall store both the site of service provider NPI and legacy numbers.							X	
6001.63	Although the requirements of this CR represent an attempt to automate as much as possible the adjudication of claims under this demonstration, special circumstances may arise which require manual overrides. Under exceptional conditions, A/B MACs shall have the capability to manually override how claims are processed.	X				X		X	

Number	Requirement								
		A/B MAC	DME MAC	RHHI	Shared-System Maintainers				OTHER
					FISS	MCS	VMS	CWF	
6001.64	Upon receipt of the claim from the A/B MAC, the CWF will first check to see if there is an auxiliary record from an NOA on file for the beneficiary. If there is no NOA on file for the beneficiary, the CWF will process the claim as it would a traditional FFS Part B claim and send a response back to the A/B MAC as appropriate.	X				X		X	
6001.65	If there is an auxiliary record reflecting an active NOA on file for the beneficiary (i.e., the NOA was submitted and not cancelled), CWF shall check whether the date of service on the claim falls on or between the admission and discharge date (inclusive of both dates) on the NOA.							X	
6001.65.1	If the date of service on the claim does NOT fall on or between the admission and discharge date (inclusive of both dates) on the NOA, the CWF will follow traditional FFS processing rules and send a response back to the A/B MAC as appropriate.							X	
6001.66	If there is no discharge date on the NOA yet (i.e., because CWF has not received the final bill with a discharge date with which to "revoke" the NOA), then CWF shall check to see if the dates of service fall on or after the date of admission on the NOA.	X						X	
6001.66.1	If there is no discharge date on the NOA and the dates of service on the claim do NOT fall on or after the date of admission on the NOA, the CWF will follow traditional FFS processing rules and send a response back to the A/B MAC as appropriate.							X	
6001.67	If there is a matching NOA and the date of service on the claim falls between the admission and discharge date (exclusive of either date) on the NOA, and the place of service on the claim is 21, 22,23 or 81, CWF shall "reject the claim back to the A/B MAC" with an error code and trailer which will indicate that this is a demonstration claim to be processed as a "no pay claim". CWF shall not need to check the site of service provider	X				X		X	

Number	Requirement	A/B MAC	DME MAC	RHHI	Shared-System Maintainers FISS	MCS	VMS	CWF	OTHER
	number under these circumstances. If the service occurs during an admission covered under the demonstration, but not on either the admission or discharge date, the assumption is that the service has been provided at another facility through a special arrangement with the demonstration facility which will be responsible for covering the costs of that service (both the facility and physician components).								
6001.68	If there is a matching NOA and the date of service on the claim falls on the admission or discharge date on the NOA, then CWF shall check to determine whether the site of service provider ID (NPI) has been filled in. If the site of service provider ID is filled in, CWF shall map the site of service NPI to the legacy provider number and check to determine whether the site of service on the claim matches the hospital on the NOA. If there is a match and the place of service on the claim is 21, 22,23 or 81, CWF will “reject the claim back to the A/B MAC” with an error code and trailer which will indicate that this is a demonstration claim to be processed as a “no pay claim” . A payment/denial code of “D” (Denied due to Demonstration Involvement) shall be used. .	X				X		X	
6001.69	If there is a matching NOA and the date of service on the claim falls on the admission or discharge date on the NOA, and the site of service provider number is on the claim and the number does not match the provider on the NOA, then the CWF will follow traditional FFS processing rules and send a response back to the A/B MAC as appropriate. This will allow for traditional fee-for-service payment in situations where patients are	X				X		X	

Number	Requirement	A/B MAC	DME MAC	RHHI	Shared-System Maintainers FISS	Shared-System Maintainers MCS	Shared-System Maintainers VMS	Shared-System Maintainers CWF	OTHER
	transferred to or from demonstration hospitals. For example, if a doctor treats and stabilizes a beneficiary in the emergency room of a non-demonstration hospital and then transfers that patient to a demonstration hospital, she/he is eligible to be paid under the traditional fee for service Medicare program for those services.								
6001.70	If there is a matching NOA and the date of service on the claim falls on the admission or discharge date on the NOA, then CWF shall check to determine whether the site of service provider ID (NPI) has been filled in. If the site of service provider ID (NPI) has not been filled in, then the claim shall be returned to the provider to re-submit the bill with the appropriate site of service provider ID (NPI) on the claim.	X				X		X	Physicians
6001.70.1	CWF shall reject the claim to the A/B MAC with an error code and trailer that will indicate the site of service NPI is needed							X	
6001.71	If there is no discharge date on the NOA, but the date of service is on or after the date of admission on the NOA and the site of service provider ID on the claim does not match the provider on the NOA, then the CWF will also follow traditional FFS processing rules and send a response back to the A/B MAC as appropriate. The assumption is that the claim is not going to be covered under the global payment.	X				X		X	
6001.71.1	After the final discharge bill is received and the discharge date is put on the NOA, if the date of service on the claim falls between the admission and discharge date (but does not equal either), the claim will be adjusted and processed on a no pay basis in accordance with the provisions of the demonstration.	X				X		X	
6001.72	If there is no discharge date on the NOA, but	X				X		X	

Number	Requirement	Responsibility							
		A/B MAC	DME MAC	RHHI	Shared-System Maintainers				OTHER
					FISS	MCS	VMS	CWF	
	the date of service is on or after the date of admission on the NOA; and the site of service provider ID on the claim MATCHES the provider on the NOA; and the place of service on the claim is 21, 22,23 or 81; CWF shall "reject the claim back to the A/B MAC" with an error code and trailer which will indicate that this is a demonstration claim to be processed as a "no pay claim". A payment/denial code of "D" (Denied due to Demonstration Involvement) shall be used.								
6001.72.1	After the final discharge bill is received and the discharge date is put on the NOA, if the date of service on the claim falls after the discharge date, the claim will be adjusted and processed on a fee for service basis.	X				X		X	
6001.73	When CWF returns a claim to the A/B MAC which it has determined should be processed as a "no pay" claim under the rules of one of these demonstrations, CWF shall also provide a "trailer record" to the A/B MAC indicating the hospital where the services were provided, the date of admission, and, if available, the date of discharge. This information shall come from the NOA auxiliary record which is stored by CWF, and shall be used by the A/B MAC, in conjunction with data from the Part B claims, to prepare reports for the participating demonstration hospitals.	X				X		X	
6001.74	After the A/B MAC processes the no pay claim, the A/B MAC will send the claim back to CWF, which will "accept" it and also send the claim to the national claims history file.	X				X		X	
6001.74.1	Once "accepted" by CWF, the A/B MAC will send the appropriate notices to the provider.	X				X		X	
6001.75	If a beneficiary has multiple, overlapping open NOAs specific to the demonstration, CWF shall match claims based on the demonstration							X	

Number	Requirement	A/B MAC	DME MAC	RHHI	Shared-System Maintainers				OTHER
					FISS	MCS	VMS	CWF	
	number and then the site of service ID (NPI) on the claim.								
6001.75.1	If the site of service is not on the claim, CWF shall reject the claim to the A/B MAC with an error code and trailer that will indicate the site of service NPI is needed	X				X		X	
6001.76	All physician and professional practitioner claims related to the demonstration will be processed by the A/B MACs as “no pay” claims. However, all claims must be processed according to traditional Medicare FFS rules in order to determine the amount that would have been paid had it not been for the demonstration.	X				X		X	
6001.77	The remittance advice sent to the professional provider should note the substituted payment provisions of the demonstration.	X				X			
6001.77.1	A/B MACs should use remark code N67: Professional provider services not paid separately. Included in facility payment under a demonstration project. Apply to that facility for payment, or resubmit your claim if: The facility notifies you the patient was excluded from this demonstration; or if you furnished these services in another location on the date of admission or discharge from a demonstration hospital. If services furnished in a facility not involved in the demonstration on the same date the patient was discharged from or admitted to a demonstration facility, you must report the provider ID number for the non-demonstration facility on the new claim.	X				X			
6001.78	Physician or other professional provider demonstration claims which are processed by the A/B MAC on a “no pay" basis shall not be sent to any of the "screens" (e.g., surgery, cancer, etc.) in CWF.							X	
6001.78.1	However, services that have coverage limits	X				X		X	

Number	Requirement	A/B MAC	DME MAC	RHHI	Shared-System Maintainers FISS	MCS	VMS	CWF	OTHER
	and would not be covered even in the absence of the demonstration should be handled as they would under traditional fee-for-service Medicare and should not be processed as "no pay" in accordance with demonstration rules.								
6001.78.2	Services that are not paid due to coverage limits shall not be tagged with a demonstration code							X	
6001.78.3	Demonstration hospitals shall not be responsible for reimbursing other Part B providers for any services rendered during the inpatient stay for which Medicare would not otherwise pay.								Demo Hospitals
6001.79	In the case where the claim is to be processed as a "no pay claim" (with payment /denial code "D") because payment is covered under the global payment to the hospital, the A/B MAC should put the demonstration number on the claim. This process should be automated to reduce or eliminate manual handling of demonstration claims.	X				X		X	
6001.79.1	The Demonstration ID number is **<u>54</u>**. There will be a single demonstration ID number for all hospitals participating in the demonstration. Physicians billing for services that will ultimately be processed as 'no pay' claims are not required to submit claims with the demonstration ID number.								Physicians
6001.80	Physicians and other professional practitioners eligible for pay for performance (P4P) or other incentive payments shall continue to be eligible to receive these P4P incentives to the same extent they would be in the absence of the demonstration. Therefore, claims processed as 'no pay' under the demonstration are eligible for consideration in any pay for performance or other incentive program to the extent they meet those program requirements.	X				X			P4P Contractors - P4P Lump Sum Bonus file

Number	Requirement	A/B MAC	DME MAC	RHHI	Shared-System Maintainers FISS	MCS	VMS	CWF	OTHER
6001.81	Physicians and other Part B professional providers shall be required to accept assignment for all claims covered under the global payment.	X							Physicians
6001.81.1	Physicians shall be notified of this requirement through educational efforts prior to and during the demonstration that are conducted by A/B MACs, and the demonstration hospital.	X							Demo Hospitals
6001.81.2	Contractors shall update the assignment field as necessary when processing claims.	X							
6001.82	If a physician bills for services on a non-assigned basis for services for a beneficiary for whom a potentially matching NOA is identified, and a provider site of service is needed to determine if the services are covered under the demonstration, then that claim shall be processed in the same way that a claim submitted on an assigned basis would be handled under the rules of this demonstration.	X				X		X	Physicians
6001.82.1	CWF shall reject the claim to the A/B MAC with an error code and trailer that will indicate the site of service NPI is needed.							X	
6001.82.2	The A/B MAC shall deny the claim with the same message that is used for assigned claims and the provider shall be instructed to provide additional site of service information in order to have the claim processed.	X							
6001.83	For demonstration claims, the Part B deductible, blood deductible, or coinsurance shall not be applied nor shall any of them be posted to the beneficiary history.	X				X		X	
6001.84	All Medicare Summary Notices (MSNs) from the A/B MAC for "no pay" physician claims applicable to demonstration patients shall be suppressed.	X				X			
6001.84.1	Information related to Part B payments shall be included on the MSN sent by the A/B MAC in response to the institutional claim	X			X				
6001.85	A/B MACs and the standard system shall use	X				X		X	

Number	Requirement	A/B MAC	DME MAC	RHHI	Shared-System Maintainers				OTHER
					FISS	MCS	VMS	CWF	
	all current edits (including current duplicate logic) on demonstration claims. Auto-adjudication logic may still be applied.								
6001.85.1	Claims denied for reasons not related to the demonstration shall be processed with the appropriate routine denial reason codes and shall not be tagged with the demonstration code (54).	X				X		X	
6001.86	Irregularities that may indicate potential fraudulent behavior shall be reported in accordance with standard Medicare procedures.	X							
6001.86.1	As part of the independent evaluation of the demonstration, an analysis of demonstration claims shall be performed by the CMS evaluation contractor.								CMS Evaluation Contractor
6001.87	Claims shall be counted as part of the normal monthly workload for all contractors as CWF no payment bills.	X				X			
6001.87.1	Report the number of no-payment demonstration claims processed on line 11 (Claims Denied) on the monthly Medicare Program Carrier Performance Report - Page 1 (Form HCFA-1565). Line 11 is a subset of line 15 (Total Claims Processed), which is the basis for estimating the claims processed workload in the administrative budget process. Also, report these claims on line 18 (Other) on the Medicare Program Quarterly Supplement to the Carrier Performance Report (Form HCFA-1565A).	X				X			
6001.88	The demonstration claims shall be deleted from the Automated Response Unit (ARU) system.	X			X	X			
6001.88.1	Requests for information shall be forwarded to a live representative at the A/B MAC site.	X			X	X			
6001.88.2	The ARU message should not be changed in order to try and accommodate the demonstration.	X			X	X			
6001.89	Demonstration claims will not be subject to appeals based on processing according to demonstration specific requirements.	X			X	X			

Number	Requirement	A/B MAC	DME MAC	RHHI	Shared-System Maintainers FISS	Shared-System Maintainers MCS	Shared-System Maintainers VMS	Shared-System Maintainers CWF	OTHER
	Claims may continue to be appealed for reasons unrelated to demonstration processing.								
6001.89.1	Message N83 shall be used: **N83** No appeal rights. Adjudicative decision based on the provisions of a demonstration project	X			X	X			
6001.90	Demonstration claims shall be excluded from medical review savings reports.	X							
6001.91	Correct Coding Initiative activities shall continue as usual	X							
6001.92	In order to provide demonstration hospitals with information on "no pay" physician/supplier claims that have been processed for services provided to beneficiaries covered under the demonstration at their hospital, A/B MACs shall develop the capability to accept, store, and access the trailer records with claim and NOA specific information that CWF is being directed to provide.	X				X		X	
6001.92.1	Weekly reporting shall be required as defined in 6001.94 and referenced in 6001.93, below. This function shall be automated to the extent practical to eliminate the need for routine manual processes.	X				X		X	
6001.93	On a weekly basis, the A/B MACs shall prepare a report for each demonstration hospital showing all Part B demonstration claims (i.e., those processed as "no pay") processed in the previous week for services rendered at that demonstration hospital. The report shall also show demonstration claims that have been retroactively adjusted and re-processed as traditional Medicare fee-for-service claims. The intent of this report is to allow the hospital to determine how the global payment should be distributed. The report should be sorted by beneficiary, date of admission, Part B provider,	X				X			

Number	Requirement	A/B MAC	DME MAC	RHHI	Shared-System Maintainers				OTHER
					FISS	MCS	VMS	CWF	
	and date of service. The report shall include a record for each claim line processed and the amount that would have normally been paid under traditional Medicare fee for service rules for each covered service. Attachment IV shows a sample format for the report along with a definition of the fields to be included.								
6001.94	A/B MACs and the standard systems shall be able to process claims from physicians that include one or more claim lines for services which are covered under the demonstration global payment and also one or more claim lines for services which are not included in the global payment. One example of such a situation might be a claim from a physician that includes both inpatient services covered under the demonstration as well as pre-admission or post discharge office-based services that are separately payable and not covered under the demonstration.	X				X		X	
6001.94.1	The A/B MAC shall split such claims into two separate claims whereby one claim shall include only services and claim lines that are covered under the demonstration, and the other claim shall include only services and claim lines that are not covered under the demonstration. Only the claim with the claim lines only for services covered under the demonstration shall be tagged with the demonstration code (“54”). The claim with the claim lines only for non-demonstration services shall be processed in accordance with traditional Medicare processing rules.	X				X		X	
	UNSOLICITED RESPONSE AND AUTO ADJUSTMENT OF CLAIMS								
6001.95	After the discharge date is put on the NOA auxiliary record as a result of processing the							X	

Number	Requirement	A/B MAC	DME MAC	RHHI	Shared-System Maintainers				OTHER
					FISS	MCS	VMS	CWF	
	final hospital bill (thereby effectively ending the NOA period), CWF shall "look back" and check all hospital based physician or other professional claims *at the claim line level* for previously adjudicated services "related" to the inpatient admission which were processed and paid under traditional fee for service rules, but which should be included in the global payment. Whether a claim is covered under the demonstration is determined by two factors: date of service and site of service as defined in the business requirements of this CR. This includes only services provided at a hospital location, i.e., where the place of service on the claim line is “inpatient”, “outpatient”, emergency room”, or at an independent laboratory or diagnostic facility (place of service code = 21, 22, 23, or 81). Services provided at a doctor’s office or any other location, for example, on the admission or discharge date are not considered as part of the inpatient stay for purposes of inclusion in the global payment. Claims from DME suppliers, ambulance providers, etc., are not part of the global payment and are processed according to traditional fee for service Medicare rules. As a result, they will not require any auto adjustment.								
6001.96	If claim lines processed under traditional Medicare FFS rules are identified which require re-adjudication under the demonstration rules, CWF shall send an unsolicited response to the A/B MAC processing the original claim. The unsolicited response indicates which services are to be automatically adjusted by the A/B MAC and why (i.e., service should have been covered under the global demonstration payment).	X				X		X	
6001.96.1	For tracking purposes, CWF will flag claim							X	

Number	Requirement	A/B MAC	DME MAC	RHHI	Shared-System Maintainers				OTHER
					FISS	MCS	VMS	CWF	
	lines to indicate that an unsolicited response has been sent to the A/B MAC.								
6001.97	In accordance with normal processing, after the A/B MAC adjusts the claim, CWF shall make sure that deductible information is updated on the beneficiary’s file for use in future processing by the A/B MAC.	X				X		X	
6001.97.1	Once a claim is adjusted, CWF must also send the adjustment to the National Claims History File.							X	
6001.98	Upon receipt of the unsolicited response file from CWF, the standard system and the A/B MAC shall read the line item information in the new trailer for each claim and perform an automated adjustment to each claim.	X				X		X	
6001.98.1	The claim will then be re-processed as a no pay claim in accordance with the processing rules under the demonstration. This includes, but is not limited to, weekly reporting of no pay demonstration claims to hospitals participating in the demonstration.	X				X		X	
6001.99	As part of the automatic adjustment process, the A/B MAC shall follow normal accounts receivable processes	X				X			
6001.99.1	The A/B MAC must follow existing remittance advice “Correction/Reversal” procedures to adjust the fee for service payment and establish the debit.	X				X			
6001.99.2	The reversal remittance advice must include remark code N68 at the claim line level. “Prior payment being canceled as we were subsequently notified this patient was covered by a demonstration project in this site of service. Professional services were included in the payment made to the facility. You must contact the facility for your payment. Prior payment made to you for this claim by the patient or another insurer must be refunded to that payer within 30 days.”	X				X			

Number	Requirement	A/B MAC	DME MAC	RHHI	Shared-System Maintainers				OTHER
					FISS	MCS	VMS	CWF	
6001.100	Claim lines awaiting payment on the payment floor may also be identified as requiring auto adjustment and reprocessing as no pay claims. Although it would be preferable to be able to stop such payments before they are actually mailed out to providers, it is recognized that this may be difficult to do and is not a requirement for auto adjusting. Thus, it is possible that a claim line which has been approved for payment but is "in the payment floor" waiting to be sent out, gets processed and sent out to the physician only to ultimately be retracted.	X				X			
6001.100.1	If there are related claim lines identified on the payment floor when the debit account is set up then the A/B MAC shall adjust the claim after it is off the payment floor and deduct the amount set up for the account from the payment amount on the claim that was paid.	X				X			
6001.100.2	The A/B MAC and standard system shall: (1) Enter reason code "CW", "claim withholding", in the provider payment adjustment segment of the remittance advice followed by the amount being recovered. (2) Enter the Health Insurance Claim Number (HIC#) for the affected claims in the provider adjustment identifier data element. (3) Use remark code "N68"	X				X			
6001.101	A/B MACs shall notify beneficiaries of claim lines, which have been auto adjusted through the normal monthly Medicare Summary Notice (MSN).	X				X			
6001.101.1	A special message, MSN # 60.11 must be used to explain the reason for the auto adjusting of the claim. MSN #60.11 English: This payment is being retracted because the services	X				X			

Number	Requirement	A/B MAC	DME MAC	RHHI	Shared-System Maintainers				OTHER
					FISS	MCS	VMS	CWF	
	provided are covered under a demonstration project in which the hospital receives payment for all physician and hospital services related to this admission. The provider should seek reimbursement directly from the hospital where the care was provided. Any deductible or coinsurance paid by you or your supplemental insurer for these services should be returned by the provider								
6001.102	If after a hospital submits an NOA and the auxiliary NOA record is established, the hospital determines that the beneficiary will not have services covered under the demonstration, the hospital shall submit a cancellation of the NOA as soon as possible in order minimize errors or delays in processing of either the hospital or associated professional claims.								Demo Hospital
6001.103	If an NOA is cancelled, the hospital shall notify physicians who may have submitted bills to the A/B MAC and had them processed as “no pay” under the demonstration that the services may now be eligible for payment under traditional Medicare Part B rules.								Demo Hospital, Physician
6001.104	Upon receipt of a cancellation to an NOA, CWF shall initiate a “look back” into the claims history records to identify demonstration claims- i.e., Part B physician or other professional claims - which were processed as "no pay" as a result of the NOA being opened. These claims may be identified by the demonstration number on them (54).							X	
6001.105	If there are any no pay claims identified relating to the canceled NOA, CWF shall send an unsolicited response to the A/B MAC originally processing the claim directing that the claim be automatically adjusted.	X				X		X	
6001.105.1	For tracking purposes, CWF shall flag claim lines to indicate that an unsolicited response has been sent to the A/B MAC.							X	
6001.106	In accordance with normal processing, after the A/B MAC adjusts the claim, CWF shall accept the claim records and send them to the national	X				X		X	

Number	Requirement	A/B MAC	DME MAC	RHHI	Shared-System Maintainers				OTHER
					FISS	MCS	VMS	CWF	
	claims history file.								
6001.106.1	In addition, CWF shall make sure that deductible information is updated on the beneficiary's file for use in future processing by the A/B MAC.							X	
6001.107	The A/B MAC shall automatically adjust demonstration claims identified by CWF by reversing the "no pay" process and processing the claim in accordance with traditional Medicare fee for service payment rules. These claims shall now be eligible for any edits or other processes applied to traditional Medicare claims.	X				X		X	
6001.108	The standard system and A/B MAC shall remove the demonstration number from the original claim as part of the adjustment process. Once adjusted, these claims shall no longer be considered demonstration claims and shall not appear as such in the National Claims History File. The adjustment claim shall not have the demonstration ID number (54) on it.	X				X			
6001.109	Physicians and other professional providers shall not be required to re-submit claims that are auto adjusted under this situation in order to be paid.	X							physicians
6001.110	The A/B MAC shall notify demonstration hospitals of demonstration claims that are auto adjusted on the demonstration reports that are sent weekly to them. Demonstration claims that are auto adjusted and subsequently paid on a fee for service basis must be specially indicated as such to insure that hospitals are aware that these are NO LONGER covered under the demonstration	X			X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	A/B MAC	DMERC	RHHI	Shared-System Maintainers FISS	MCS	VMS	CWF	OTHER
6001.111	A provider education article related to this instruction will be available at www.cms.hhs.gov/MLNMattersArticles prior to the demonstration being implemented. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in the next regularly scheduled bulletin after the article becomes available and incorporated into any educational events on this topic. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X							CMS Demo staff Education article will also be sent to Medi-Gap, Meicaid and Other Employer Health Plans

IV. SUPPORTING INFORMATION

Please see Attachments I, II, III, IV, and V

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
1	The following transmittals / CRs issued between 2001 and 2004 are relevant to this notification:

X-Ref Requirement Number	Recommendations or other supporting information:
	1. CR 1525, Transmittal AB-01-97, Issued July 17, 2001 2. CR 1752, Transmittal AB-01-149, Issued October 23, 2001 3. CR 1849, Transmittal AB-01-140, Issued September 27,2001 4. CR 1995, Transmittal AB-02-002, Issued January 11, 2002 5. CR 2382, Transmittal AB-02-144, Issued October 25, 2002 6. CR 3199, Transmittal 2, Issued April 30, 2004

B. For all other recommendations and supporting information, use the space below: N/A

V. CONTACTS

Pre-Implementation Contact(s): Rachel Duguay/410-786-6654

Post-Implementation Contact(s): Rachel Duguay/410-786-6654

VI. FUNDING

A. *For Fiscal Intermediaries and Carriers: NA*

B. *For Medicare Administrative Contractors (MACs)*, use the following statement:

This CR applies only to the MAC in MAC Jurisdiction 4 which covers the States Texas, Oklahoma, New Mexico, and Colorado.

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). 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.

It has been determined that this CR requires funding for activities outside the regular CR process. This has been arranged internally at CMS.

ATTACHMENT I

DEMONSTRATION DESIGN

1. *Beneficiary Eligibility for the Demonstration*
   These demonstrations represent an alternative to the traditional Part A and Part B fee-for-service processing systems. Therefore, patients must be eligible for Part A, enrolled in Part B, and have available at least one lifetime reserve day at the time of admission to the demonstration hospital in order to have their services covered under this demonstration. Other beneficiaries, either because their health care is paid for through other arrangements or because their inclusion would unduly complicate implementation of the demonstration, will not be eligible to participate. Specifically, the demonstration will exclude the following groups of patients:

   - Medicare beneficiaries who are enrolled in Part A or Part B only;
   - Medicare beneficiaries without any lifetime reserve days at the time of admission;
   - Medicare beneficiaries enrolled in a Medicare Advantage or other Medicare health care plan (e.g. cost plan) to which Medicare pays a monthly capitation to cover Part A and/or Part B services, receive Medicare benefits under the Railroad Retirement Board (RRB) program, or are insured by the United Mine Workers of America (UMWA);
   - "Working Aged/Disabled" Medicare beneficiaries for whom Medicare is a secondary payer for the services provided under the demonstration[1]
   - Medicare beneficiaries who are transferred to another acute care hospital paid under the inpatient prospective payment system AND for whom the length of stay is short enough such that the transferring hospital (i.e., the demonstration hospital) would be paid less than the full DRG under traditional fee-for-service Medicare processing rules.

   Services for all of the above groups of beneficiaries who are excluded from the demonstration shall be processed under traditional Part A and Part B processing rules.

   Demonstration hospitals shall be required to electronically notify the MAC whenever a beneficiary to be covered under the demonstration is admitted to the hospital. The notification process used shall be based upon the notice of election process (hereafter referred to as a "Notice of Admission (NOA)" for this demonstration) used to elect hospice benefits and/or receive services by a religious non-medical health care facility,.

2. *Geographic Area for the Demonstration*
   The ACE demonstration will accept applications from qualified providers in MAC Jurisdiction 4 which includes Texas, Oklahoma, New Mexico, and Colorado.

[1] Medicare must be the primary payer. Working aged/disabled beneficiaries with health insurance coverage through their own or a spouses employer group plan are not eligible to participate in the demonstration if that plan is primary. Individuals eligible for Medicare on the basis of ESRD for whom a GHP is primary to Medicare during the 30-month coordination period are not eligible to participate. Beneficiaries with an MSP indicator of auto liability or workers compensation or other MSP indicator shall be eligible to participate in the demonstration as long as Medicare would be the primary payer for all services covered in the demonstration.

3. *Services Covered Under the Demonstration*
   Demonstration sites will be paid a single global payment for all inpatient facility and professional services provided to beneficiaries discharged with the DRGs covered under the demonstration for that site. During the course of the demonstration, the list of covered DRGs may be updated by CMS. Notification of such changes will be made to the contractors in a separate PM.

4. *Pricing*
   The global payment will be negotiated between CMS and each demonstration site. For any given DRG, payments will be specific to each demonstration site. CMS staff will provide contractors with specific rate information at least 60 days in advance of the effective date of any rate changes in a format to be mutually agreed upon. Although, in general, rate changes shall occur on an annual basis, more or less frequent updates are possible.

   The global payment shall include all claims for professional services provided to the beneficiary from the date of admission through the date of discharge at the demonstration facility (place of service = inpatient (code = 21) outpatient (code =22), or emergency room (code = 23). In addition, claims for professional or technical laboratory or other diagnostic services that are provided off site for a beneficiary who is an inpatient at a demonstration facility on the date of service will be included in the global payment (Place of service = 81). Claims from DME suppliers, ambulance providers, etc. will not be part of the demonstration and will be processed according to traditional fee for service Medicare rules.

   Claims for pre-admission testing, readmissions, and physician services included within the standard global surgical fee will continue to be handled as they are for all other admissions under regular Medicare fee-for-service reimbursement rules. For example, pre-admission testing the day before an admission is included in the global rate if it would be included in the DRG under traditional Medicare processing. Similarly, under a global payment, if a surgeon submits an outpatient or office based claim for a follow up, it would not be paid separately and would be considered to have been included in the global payment just as, under fee for service rules, it would be considered to be part of the Part B global surgical fee.

   Professional services provided in the emergency room of the demonstration facility on the date of admission shall be included in the global payment, but services provided at the emergency room of a non-demonstration hospital on the date of admission or date of discharge from the demonstration hospital shall be paid under traditional Medicare processing rules. Thus if a patient is seen in a non-demonstration hospital emergency room and transferred to a demonstration participating hospital, all services at the initial emergency room shall be paid according to traditional Medicare fee-for-service processing rules.

   The global payment shall also include any professional or technical fees for services provided by laboratories or other diagnostic facilities that are not billed by the demonstration hospital but which provide services to the beneficiary during the inpatient stay. Payment for these services shall be included in the bundled payment to the demonstration hospital and the demonstration hospital shall be responsible for compensating the provider of such services directly.

   There will be no additional payment for outlier stays under this demonstration. An adjustment for outliers will be included in the negotiated rates However, facility payments for indirect graduate

medical education (IME), disproportionate share (DSH), and new technology will continue to be processed as they are under the traditional Medicare Part A processing.

Pass-throughs (e.g. direct medical education) will continue to be processed as they are now under the traditional fee-for-service Medicare program.

It is also the intent that operational IME and operational DSH, which are paid on an interim basis with each claim, should continue to be paid as they would be in the absence of the demonstration. Interim operational IME & DSH payments which are calculated in the pricer module should continue to be added to the global DRG payment at the time the claim is processed. During the settlement and reconciliation process, all hospital days, including those for demonstration patients, should be included.

The global payment will be subject to the inpatient Part A deductible as well as any Part A copayments that might be applicable. For the Part B component of the global payment, a fixed copayment will be predetermined for each hospital and DRG reflecting an actuarial estimate equivalent to 20 percent of the portion of the global payment attributable to Part B services. No Part B deductible will be applied. Under this demonstration, beneficiaries may be eligible to receive an incentive payment. Incentive payments will be handled separately by CMS and outside of the traditional claims processing system.

It is intended that the cost reports and settlement for disproportionate share and indirect medical education be processed based on what the MAC would have paid for Part A services in the absence of the demonstration. In processing claims, the processed claim record must indicate what portion of the global payment is attributable to Part A demonstration payment and the Part B demonstration payment. These amounts will be on the look up table provided by the CMS demonstration project officer. Splitting out the payment will insure that the money comes out of the appropriate trust fund. However, the claim record must also show what would have been paid for Part A services in the absence of the demonstration, including all outlier payments. Separation of demonstration claims will not be required on the "Provider Statistics and Reimbursement (PSR)" reports although, if needed, the demonstration number will be on every claim for subsequent “back end” reporting purposes.

If a claim for associated professional services is processed as a “no pay” claim under the rules of the demonstration and it is subsequently determined that a beneficiary is not eligible for coverage under such rules, then that claim shall be automatically reprocessed according to traditional Medicare fee for service rules. The professional provider shall not have to re-submit the claim. If a claim is processed and paid as a fee for service claim, the systems shall be set up to automatically identify such claims, re-process them under the rules of the demonstration, and recoup payment.

5. *Special Circumstances*

5.1. *Acute Inpatient Hospital (PPS) Transfers*

In order to avoid the problems of calculating appropriate global per diems, when an inpatient acute care transfer occurs from a demonstration hospital to another non-demonstration PPS hospital *AND* the length of stay at the originating, demonstration hospital is short enough such that under traditional payment processing a per diem less than the full DRG payment would be made, payment shall revert to traditional separate Part A and Part B processing rules.

If a patient is transferred to a demonstration hospital from a non-demonstration PPS hospital, the originating hospital and its associated providers are to be paid according to regular Medicare FFS payment rules. Claims for services by providers at the originating hospital, including those provided on the date of discharge or transfer, are not covered under the global reimbursement rate. Only services provided by physicians at the demonstration hospital on the date of admission or discharge are to be reimbursed under the global payment, but services provided by physicians at other hospitals on those days will be paid under the traditional fee-for-service Medicare program rules. Providers will have to bill with the non-demonstration hospital site of service provider ID on the claim in order to receive payment.

5.2. *Post Acute Care (PAC) Transfers*
In FY 1999, pricing edits were implemented for certain DRGs when the patient was "transferred" to a post acute provider (skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency care, etc.) and the patient's length of stay was one or more days less than the geometric mean for that DRG. Because the negotiated global payments already adjust for these shorter stays, these edits should NOT be applied to claims under this demonstration.

5.3. *Health Professional Shortage Area (HPSA) Bonus Payments*
Providers who would otherwise be eligible for HPSA bonus payments for services provided to beneficiaries in the absence of these demonstrations should continue to receive them under the demonstration. Physicians will be directed to submit no pay claims with all of the necessary modifiers and other information required for this purpose. However, HPSA payments are calculated based on actual payments and demonstration claims will be processed as “no pay” claims. Therefore, at the time HPSA payments are calculated, the system must also estimate what would have been paid for demonstration claims (e.g., Medicare allowable x 80 percent; because demonstration claims will not be subject to the Part B deductible, this does not need to be figured into the calculation).

5.4. *Other Bonus Payments*-

Physicians eligible for pay for performance incentive payments in effect during the course of the demonstration will continue to be eligible for such additional payments during the demonstration to the same extent they would otherwise be eligible for them in the absence of the demonstration. For example, if an incentive payment is tied to allowable charges and a claim is processed under the demonstration as a ‘no pay’ claim, then the incentive shall include what Medicare would have paid for that service in the absence of the demonstration.

6. *Full Access to Any Medicare Provider*
There will be no attempt to restrict beneficiary access to any providers under this demonstration. However, all physicians practicing at demonstration hospitals will be subject to the payment provisions of the demonstration if they provide services to beneficiaries whose admissions are covered under the demonstration rules. Similarly, all beneficiaries who chose to go to a demonstration hospital for services covered under the demonstration and who are eligible for the demonstration, will have their claims processed under demonstration rules. Neither hospitals nor

physicians may exclude beneficiaries from the demonstration unless they meet the explicit exclusion requirements specified in this notification.

7. *Payment Processing*

The goal of this notification is to develop and implement the administrative infrastructure to allow for efficient operations and the building of an automated global claims processing capability. Attachment III includes a series of flow charts as reference to the process described in the business requirements stated below. The business requirements are organized into sections corresponding to the flow charts. However, the latter are intended to provide a high level conceptual and logical outline of the process. Where differences exist, the business requirements shall take precedence.

ATTACHMENT II

FINAL FY '08 DRG #	Description
216, 217, 218, 219, 220, 221	Cardiac valve and other major cardiothoracic procedure with cardiac catherization with MCC; with CC; without CC/MCC; cardiac valve and other major cardiothoracic procedure without cardiac catherization with MCC; with CC; without CC/MCC, respectively.
231, 232	Coronary Bypass w/PTCA with MCC and w/o MCC, respectively
246	Perc cardiovasc proc w drug-eluting stent w MCC or 4+ vessels/stents
247	Perc cardiovasc proc w drug-eluting stent w/o MCC
248	Perc cardiovasc proc w non-drug-eluting stent w MCC or 4+ ves/stents
249	Perc cardiovasc proc w non-drug-eluting stent w/o MCC
260, 261, 262	Cardiac pacemaker revision except device replacement, with MCC, with CC, and w/o CC/MCC, respectively
258, 259	Cardiac pacemaker device replacement with and w/o MCC, respectively
226, 227	Cardiac defibrillator implant w/o cardiac cath w and w/o MCC, respectively
250, 251	Percutaneous cardiovasc proc w/o coronary artery stent or AMI w and w/o MCC, respectively
233, 234	Coronary bypass w cardiac cath w MCC and w/o MCC, respectively
235, 236	Coronary bypass w/o cardiac cath w and w/o MCC, respectively
242	Permanent cardiac pacemaker impl w MCC
243, 244	Other permanent cardiac pacemaker implant w CC and w/o CC/MCC, respectively
461, 462 Exclude ICD-9 code 81.56	Bilateral or multiple major joint procs of lower extremity
488, 489	Knee procedures w/o PDX of infection
469, 470 Exclude ICD-9 codes 84.26, 84.27, and 84.28	Major joint replacement or reattachment of lower extremity (excludes forms of limb reattachment)
466, 467, 468	Revision of hip or knee replacement

Note: CC and MCC refer to "complications and comorbidities" and "multiple complications and comorbidities", respectively, whereas "w/o CC" and "w/o MCC" refer to "without complications and comorbidities" and "without multiple complications and comorbidities", respectively.

ATTACHMENT III
Systems Flow Charts

A. Notice of Admission Process
B. Discharge Billing Process
C. Part B Claims Processing

(Insert updated flow charts)

ATTACHMENT IV
Weekly Report to Demonstration Hospitals From MACs Showing Part B Claims Processed as "No Pay Bills" and Adjustments to Claims Previously Processed as "No Pay Bills"

Facility NPI: XXXXXXXX										
HCN	Beneficiary Last Name / First Name, MI	Medicaid Dual ? (Y/N)	Admit Date	Discharge Date	Provider NPI	Part B Provider: Last Name/First Initial	Service Date	Procedure Code w/Modifiers	Part B Allowable Charge[2]	Adjustment Indicator

Data Dictionary

Data Element(s)	Definition / Format	Source
Facility Tax ID Number	Tax ID number of hospital where services took place`	NOA
Facility NPI	NPI of hospital where services took place	From NOA
Facility Name	Name of hospital where services took place	NOA
Facility Address	Street Address, City, State and Zip Code of hospital where services took place	NOA
HICN	Beneficiary Health Insurance Claim Number	Claim
Beneficiary Name	Name of the Beneficiary Last Name, First Name, Middle Initial	Claim
Medicaid Dual ?	Whether the covered beneficiary is also dual	CWF (?)

[2] Claims previously processed as 'no pay' claims which, as a result of a change to an NOA, are adjusted and re-processed under traditional Medicare FFS rules should be shown as a negative amount

(Y/N)	eligible for Medicaid as well as Medicare	
Date of Admission	The Date the patient was admitted to the hospital (MMDDYY)	NOA
Date of Discharge	The date the patient was discharged from the hospital. (MMDDYY)	NOA
Provider NPI	The NPI of the provider rendering the service	Claim
Part B Provider Name	The name of the individual that rendered the service to the patient (Last name, First Initial)	Claim
Service Date	The date the service was rendered to the beneficiary	Claim
Procedure code	The HCPCS/CPT-4 code that describes the service	Claim
Modifier(s) (1-4)	Codes identifying special circumstances related to the service.	Claim
Medicare Part B Allowance	The amount that would have been allowed on this claim if it was not a demonstration no-pay claim (Numeric S9(9)v99)	Claim
Adjustment Indicator	An indicator to indicate that a claim has been adjusted and/or the claim was originally processed as a no pay claim but has been reversed as a result of a voiding or other change to the NOA. A unique code shall be used to indicate claims that are adjusted and no longer included in the demonstration.	Claim

ATTACHMENT V

FIELDS REQUIRED ON NOTICE OF ADMISSION (NOA) FORM

FL 1. 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. Provider FAX numbers are also desirable.

FL 4. Type of Bill (Required). Enter the three-digit numeric type of bill code: 11A, or 11D as appropriate. 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.

3rd Digit - Frequency.
- A - admission / election notice
- D - cancellation

FL 8. Patient's Name (Required). Show the patient's name with the surname first, first name, and middle initial, if any.

FL9. 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.

FL 10. 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.

FL 11. Patient's Sex (Required). Show an "M" for male or an "F" for female.

FL 12. Admission Date (Required). Enter the admission date. Show the date numerically as CCYYMMDD.

FL 51. National Provider Identifier (Required). This is the six-digit number assigned by Medicare plus any additional characters assigned by the MAC.
NOTE- In addition to legacy Medicare provider –identification numbers, the system shall record and transmit on the NOA, the actual National Provider Identifier (NPI). However, in accordance with standard processing guidelines, the NPI shall be mapped to the traditional Medicare Provider Identification number for processing.

FL 58. Insured's Name (Required). Enter the beneficiary's name on line A if Medicare is the primary payer. *(If Medicare is not the primary payer, the beneficiary is ineligible for these demonstrations.)* Show the name as on the beneficiary's HI card.

FL 60. 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.