CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-19 Demonstrations	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 187	**Date: November 22, 2017**
	Change Request 10044

Transmittal 177, dated August 4, 2017, is being rescinded and replaced by Transmittal 187, dated, November 22, 2017 to remove FISS and the Part A MACs from several business requirements. All other information remains the same.

SUBJECT: Next Generation Accountable Care Organization (NGACO) Year Three Benefit Enhancements

I. SUMMARY OF CHANGES: The aim of the Next Generation Accountable Care Organization (NGACO) Model is to improve the quality of care, population health outcomes, and patient experience for the beneficiaries who choose traditional Medicare fee-for-service (FFS) through greater alignment of financial incentives and greater access to tools that may aid beneficiaries and providers in achieving better health at lower costs. In order to emphasize high-value services and support the ability of ACOs to manage the care of beneficiaries, CMS is issuing the authority under section 1115A of the Social Security Act (section 3021 of the Affordable Care Act) to conditionally waive certain Medicare payment requirements as part of the NGACO Model. An ACO may choose not to implement all or any of these benefit enhancements. Applicants will be asked questions specific to their proposed implementation of these benefit enhancements, but acceptance into the Next Generation ACO Model is not contingent upon an ACO implementing any particular benefit enhancement.

Participants in the Next Generation ACO Model are required to provide implementation information to CMS, which, upon approval, will enable the ACO's use of the optional benefit enhancements. Each optional benefit enhancement will have such an "implementation plan" requiring, for example: (1) descriptions of the ACO's planned strategic use of the benefit enhancement; (2) self-monitoring plans to demonstrate meaningful efforts to prevent unintended consequences; and (3) documented authorization by the governing body to participate in the benefit enhancement.

This CR provides instruction to Medicare payment contractors to implement one new benefit enhancements for program year three of the NG ACO program. Claims for Asynchronous Telehealth Waiver shall be processed for reimbursement and paid when they meet the appropriate payment requirements as outlined in this CR.

EFFECTIVE DATE: January 1, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 2, 2018

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	N/A

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

IV. ATTACHMENTS:

Demonstrations

Attachment - Demonstrations

Pub. 100-19	Transmittal: 187	Date: November 22, 2017	Change Request: 10044

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SUBJECT: Next Generation Accountable Care Organization (NGACO) Year Three Benefit Enhancements

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

A. Background: The aim of the Next Generation Accountable Care Organization (NGACO) Model is to improve the quality of care, population health outcomes, and patient experience for the beneficiaries who choose traditional Medicare fee-for-service (FFS) through greater alignment of financial incentives and greater access to tools that may aid beneficiaries and providers in achieving better health at lower costs. In order to emphasize high-value services and support the ability of ACOs to manage the care of beneficiaries, CMS is issuing the authority under section 1115A of the Social Security Act (section 3021 of the Affordable Care Act) to conditionally waive certain Medicare payment requirements as part of the NGACO Model. An ACO may choose not to implement all or any of these benefit enhancements. Applicants will be asked questions specific to their proposed implementation of these benefit enhancements, but acceptance into the Next Generation ACO Model is not contingent upon an ACO implementing any particular benefit enhancement.

Participants in the Next Generation ACO Model are required to provide implementation information to CMS, which, upon approval, will enable the ACO's use of the optional benefit enhancements. Each optional benefit enhancement will have such an "implementation plan" requiring, for example: (1) descriptions of the ACO's planned strategic use of the benefit enhancement; (2) self-monitoring plans to demonstrate meaningful efforts to prevent unintended consequences; and (3) documented authorization by the governing body to participate in the benefit enhancement.

RTI International is the specialty contractor creating the NGACO provider alignment files.

This CR provides instruction to Medicare payment contractors to implement one new benefit enhancements for program year three of the NG ACO program. Claims for Asynchronous Telehealth shall be processed for reimbursement and paid when they meet the appropriate payment requirements as outlined in this CR.

Asynchronous Telehealth

CMS has made available to qualified NGACOs a waiver of the requirement that beneficiaries be located in a rural area and at a specified type of originating site in order to be eligible to receive telehealth services. This benefit enhancement allows payment of claims for telehealth services delivered by Next Generation Participants and Preferred Providers to aligned beneficiaries in specified facilities or at their residence regardless of the geographic location of the beneficiary. An interactive telecommunications system is required as a condition of payment; however, CMS will expand the existing NGACO telehealth waiver to also allow the use of asynchronous telehealth to deliver dermatology and ophthalmology services.

Asynchronous defined. Asynchronous telehealth includes the transmission of recorded health history (for example, retinal scanning and digital images such as photos) through a secure electronic communications system to a practitioner, usually a specialist, who uses the information to evaluate the case or render a service outside of a real-time or live interaction. Asynchronous telecommunications system in single media format does not include telephone calls, images transmitted via facsimile machines and text messages without visualization of the patient (electronic mail). Photographs must be specific to the patients' condition and adequate for rendering or confirming a diagnosis and or treatment plan.

Payment will be permitted for telemedicine when asynchronous telehealth in single or multimedia formats, is used as a substitute for an interactive telecommunications system for dermatology and ophthalmology services. Distant site practitioners will bill for these new services using new codes in the table below and the distant site practitioner must be a NGACO Participant or Preferred Provider.

Asynchronous telehealth based on intra-service + 5 minutes post service time

Code 1: G9868: Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the Next Generation ACO model, less than 10 minutes

Code 2: G9869: Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the Next Generation ACO model, 10-20 minutes

Code 3: G9870: Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the Next Generation ACO model, 20 or more minutes

B. Policy: Section 1115A of the Social Security Act (the Act) (added by section 3021 of the Affordable Care Act) (42 U.S.C. 1315a) authorizes the Center for Medicare and Medicaid Innovation (CMMI) to test innovative health care payment and service delivery models that have the potential to lower Medicare, Medicaid, and the Child Health Insurance Program (CHIP) spending while maintaining or improving the quality of beneficiaries' care.

The NGACO Model will implement design elements with implications for the FFS system for the third performance year that includes benefit enhancements to give ACOs the tools to direct care and engage beneficiaries in their own care.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10044.1	Effective January 1, 2018, contractors shall prepare their systems to process NG ACO asynchronous telehealth claims with dates of service January 1, 2018 and later.						X		X	STC
10044.2	The ACO-OS shall send the Multi-Carrier System (MCS) the Next Generation Accountable Care Organization (NG ACO) provider alignment file that's been updated to include indicator "2" for the						X			STC, VDCs

Number	Requirement	Responsibility: A/B MAC: A	A/B MAC: B	A/B MAC: HHH	DME MAC	Shared-System Maintainers: FISS	Shared-System Maintainers: MCS	Shared-System Maintainers: VMS	Shared-System Maintainers: CWF	Other
	Asynchronous and Synchronous Telehealth benefit enhancement. CMS shall include the following data elements/fields on the provider alignment file: 1. Record Type (Indicator values identified by a single character) 1. Asynchronous and Synchronous Telehealth = Value 2 NOTE: This includes changing logic that was implemented in CR9151 by modifying the definition for Value 2 from Telehealth to Asynchronous and Synchronous Telehealth.									
10044.3	Contractors shall note that a provider can have multiple enhancements, including Asynchronous Telehealth.						X			
10044.4	The contractors shall process NG ACO claims as Asynchronous Telehealth claims when the benefit enhancement indicator "2" is identified on the provider alignment file.						X			
10044.4.1	Contractors shall add HCPCS G9868, G9869, G9870 to the MSN HCPC descriptor file with the following long descriptions: Code 1: G9868: Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the Next Generation ACO model, less than 10 minutes Code 2: G9869: Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the Next Generation ACO model, 10-20 minutes Code 3: G9870 : Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the Next Generation ACO model, 20 or more minutes		X							

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
10044.4.1.1	The STC shall provide to ACO-OS the provider and beneficiary data to create the test files by September 18, 2017.									CMS, STC, VDCs
10044.4.1.2	The ACO-OS shall provide the provider alignment and beneficiary alignment test and final files to STC on or before the week of October 16, 2017.									CMS, STC, VDCs
10044.4.1.3	The MACs shall provide to ACO-OS the provider and beneficiary data to create the test files on or about the week of October 30, 2017.	X	X							CMS, VDCs
10044.4.1.4	The ACO-OS shall push the test files to the VDCs on or about the week of November 27, 2017 and transmit the test files with the MACs.		X							CMS, VDC, VDCs
10044.4.2	Contractors shall process NG ACO asynchronous telehealth claims when this benefit enhancement is elected by the provider for the Date of Service (DOS) on the claim, when the beneficiary is aligned for the submitted claim, and the following HCPCS codes: • G9868 • G9869 • G9870		X				X			
10044.4.3	SSMs shall consider a beneficiary aligned if the from date on the date of service on the claim is on or after the effective start date and on or before 90 days after the effective end date.						X		X	
10044.4.3.1	CWF shall generate an IUR based on beneficiary file updates for Telehealth when Enhancement Indicator ‘2’ is on the claim, using guidelines in BR10044.4.5 based on 90 Days after the effective end date. Note: CWF is updating the existing IUR process to include NG ACO Benefit Enhancement Indicator 2 for IUR code 7125.								X	
10044.4.4	Medicare contractors shall apply a rate for HCPCS codes: • G9868		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• G9869 • G9870 that will be displayed in the annual Physician Fee Schedule update.									
10044.4.5	Medicare contractors shall assign CARC 96 (Non-covered charge(s) with RARC N83 (No appeal rights. Adjudicative decision based on the provisions of a demonstration project), along with Group Code CO (contractual obligation) to those line items with HCPCS code G9868, G9869, G9870 that do not fall on or within the effective start date and effective end date of the provider on the NG-ACO Participant or Preferred Provider file with benefit enhancement indicator "2" Asynchronous Telehealth. Contractors shall reject the service. This should be applied at the line level by FISS. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		X				X			
10044.4.6	Medicare contractors shall assign CARC 96 (Non-covered charge(s) with RARC N83 (No appeal rights. Adjudicative decision based on the provisions of a demonstration project), along with Group Code CO (contractual obligation) to those line items with HCPCS code G9868, G9869, G9870 that do not fall on or within the effective start date and effective end date and on or before 90 days after the effective end date of the beneficiary alignment. Contractors shall reject the service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		X				X			
10044.5	Contractors shall process NG ACO tele health claims with Place of Service (POS) = 02 (Telehealth) when this benefit enhancement is elected by the provider for the Date of Service (DOS) on the claims, when the beneficiary is aligned for the submitted claim, and when the claim contains the following HCPCS codes: 90791, 90792, 90832, 90833,90834, 90836, 90837,		X				X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	90838, 90845, 90846, 90847, 90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961, 90963, 90964, 90965, 90966, 90967, 90968, 90969, 90970, 96116, 96150, 96151, 96152, 96153, 96154, 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99231, 99232, 99233, 99307, 99308, 99310, 99354, 99355, 99356, 99357, 99406, 99407, 99495, 99496, 99497, 99498, G0108, G0109, G0270, G0396, G0397, G0406, G0407, G0408, G0420, G0421, G0425, G0426, G0427, G0438, G0439, G0442, G0443, G0444, G0445, G0446, G0447, G0459, G0508, G0509 NOTE: This BR replaces the requirements in 9151.25.									
10044.5.1	Contractors shall process NG ACO telehealth claims for type of bill 85X, with revenue codes 96X, 97X and 98X when this benefit enhancement is elected by the provider for the DOS on the claims and when the claim contains the following HCPCS codes: 90791, 90792, 90832, 90833,90834, 90836, 90837, 90838, 90845, 90846, 90847, 90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961, 90963, 90964, 90965, 90966, 90967, 90968, 90969, 90970, 96116, 96150, 96151, 96152, 96153, 96154, 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99231, 99232, 99233, 99307, 99308, 99310, 99354, 99355, 99356, 99357, 99406, 99407, 99495, 99496, 99497, 99498, G0108, G0109, G0270, G0396, G0397, G0406, G0407, G0408, G0420, G0421, G0425, G0426, G0427, G0438, G0439, G0442, G0443, G0444, G0445, G0446, G0447, G0459, G0508, G0509, G9481, G9482, G9483, G9484, G9485, G9486, G9487, G9488, G9489. NOTE: This includes changing logic that was implemented in CR9151.25.1	X				X				
10044.6	Contractors shall process and flag NG ACO Telehealth originating site claims with benefit enhancement indicator "2" when this benefit enhancement is elected by the provider for the Date of Service (DOS) on the claim, when the beneficiary is aligned for the submitted claim, and the following HCPCS code:		X			X	X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• Q3014									
10044.6.1	Contractors shall process NG ACO telehealth claims for bill types 12X, 13X, 22X, 23X, 71X, 72X, 76X, 77X, and 85X, with revenue code 078X and 0780 when this benefit enhancement is elected by the provider for the DOS on the claims and when the claim contains the following HCPCS code: • Q3014	X				X				
10044.7	Contractors shall generate the MSN Message 61.2 defined in BR 9151.42.2 on claim details identified as related to the new Asynchronous Telehealth and the existing Synchronous Telehealth enhancement. MSN Message 61.2 English You received this telehealth service from your Next Generation Accountable Care Organization (ACO) provider. You may have received this service because of your relationship with the ACO. Ask your doctor to tell you more about your ACO. Spanish Ha recibido este servicio de telesalud de parte del proveedor de su nueva generación de organización responsable del cuidado de salud (ACO). Es posible que recibió este servicio debido a su relación con la ACO. Pregúntele a su médico que le diga más sobre su ACO. Note: This includes clarifying BR 9151.42.2.	X	X			X	X			
10044.8	For institutional claims, the Medicare contractors shall not transmit the 3-Day SNF Waiver = Value 4 if a valid qualifying hospital stay exists on the NG ACO claim. **NOTE**: This includes clarifying the logic that was implemented in CR9151.3.3 and CR9151.3.3.1 to include when the Record Type should be applied.					X				IDR, NCH
10044.9	The CWF shall include the field "CLMB-PATIENT-								X	BDC, VDCs

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
	NUM" [Patient Control Number provided on the claim from the Provider/Supplier, and included on the Remittance Advice back to the Provider/Supplier] on the Common Base Record Layout to the weekly AIPBP claim file for each NG ACO to be sent from the VDCs to the BDC. The CWF shall also add to the extract file the patient control number field for Part A claims. Note: This modified BR 9656.24 and Supporting Information found in BR 9656.26 AIPBP Proposed Claim File Layout.									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C	C E D I
		A	B	H H H		
10044.10	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. 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 sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. 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	X			

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Karin Bleeg, 410-786-5937 or karin.bleeg@cms.hhs.gov (mobile: 202-365-4347)

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

VI. FUNDING

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

ATTACHMENTS: 0