CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11742	**Date: December 9, 2022**
	Change Request 12837

Transmittal 11621 issued September 28, 2022, is being rescinded and replaced by Transmittal 11742, dated, December 9, 2022 to revise the list of impacted FVF codes listed in Appendix A and the HCPCS codes listed in Appendix B ahead of CR testing and implementation. All other information remains the same.

CONFIDENTIAL

NOTE: This information cannot be shared outside of your organization. Do not post any of the information on the Internet or Intranet.

SUBJECT: TRACK 3 OF THE MARYLAND PRIMARY CARE PROGRAM (MDPCP) - IMPLEMENTATION

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to adjust claims processing Flat Visit Fee (FVF) payments made for certain primary care services rendered by practices participating in Track 3 of the Maryland Primary Care Program (MDPCP), a component of the Maryland Total Cost of Care Model.

The new Track 3, which the MDPCP will add in 2023, is open to nonhospital-based primary care practices and their partner Care Transformation Organizations (CTOs), if any. Federally Qualifying Health Centers (FQHCs) cannot participate in Track 3. These Track 3 participants will receive a combination of claims and non-claims-based payments based on their attributed Medicare fee-for-service (FFS) beneficiaries. With fewer reporting requirements, Track 3 practices will have the flexibility to implement their own strategies that best target outcomes.

Participants in the MDPCP are primary care practices within the state of Maryland. A primary care practice may include one or more physicians, as well as non-physician providers such as nurse practitioners. Every participating practice will be given a unique practice ID by the CMS implementation support contractor. Providers in a practice will be uniquely defined by the combination of each provider's tax ID number (TIN) and national provider identifier (NPI).

Track 3 will begin operation on January 1, 2023. Current and new MDPCP participants will have the option to participate in Track 3 from that date through December 31, 2026. CMS will create a provider file that lists all participating providers and the effective and termination dates of their participation in MDPCP Track 3. A given provider (as defined by the combination of TIN and NPI) may only be active in one MDPCP practice at a time. Providers within a practice may have different effective and termination dates (e.g., as they are hired or leave the practice), but the practice itself will have its own effective and termination date for participation in the model. CMS will also create a beneficiary file detailing all attributed (which is also referred to as aligned) Medicare FFS beneficiaries to participants in MDPCP Track 3.

Participants in Track 3 receive a prospective, population-based payment (PBP), paid quarterly; a Flat Visit Fee (FVF) paid at the time of service for certain primary care services; and a Performance-Based Adjustment (PBA) applied to the PBP and FVF that is based on performance on certain quality, utilization, and efficiency

measures. The PBP and PBA shall be processed outside the fee for service claims processing system and are not addressed in this CR.

This CR implements the claims process adjustments for the FVF payments made for certain primary care services rendered by practices participating in MDPCP Track 3 to attributed beneficiaries and addresses prohibited HCPCS codes.

EFFECTIVE DATE: January 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 3, 2023

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:

Confidential

Attachment - Confidential

Pub. 100-04	Transmittal: 11742	Date: December 9, 2022	Change Request: 12837

Transmittal 11621 issued September 28, 2022, is being rescinded and replaced by Transmittal 11742, dated, December 9, 2022, to revise the list of impacted FVF codes listed in Appendix A and the HCPCS codes listed in Appendix B ahead of CR testing and implementation. All other information remains the same.

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SUBJECT: TRACK 3 OF THE MARYLAND PRIMARY CARE PROGRAM (MDPCP) - IMPLEMENTATION

EFFECTIVE DATE: January 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 3, 2023

I. GENERAL INFORMATION

A. Background: In 2019, the State of Maryland and the Innovation Center launched the Maryland Total Cost of Care Model to continue the statewide care transformation initiated under the previous Maryland All-Payer Model. A component of the Total Cost of Care Model is the Maryland Primary Care Program (MDPCP), which further reduces hospital spending under the global budget system (carried over from the All-Payer Model) by reducing hospitalization rates throughout the state. The MDPCP, whose structure is similar to the Comprehensive Primary Care Plus (CPC+) Model, creates comprehensive primary care transformation that focuses on rewards for effective care management provider performance and population health improvement throughout the state.

MDPCP participants currently include nonhospital-based primary care practices, Federally Qualified Health Centers (FQHCs), and Care Transformation Organizations (CTOs), a new entity created under the Model. Participants enter into an alternative payment arrangement with the Innovation Center, participating in one of two Tracks: Track 1, which includes Care Management Fees (CMFs) and a Performance-Based Incentive Payment (PBIP); and the more advanced Track 2, which includes the CMF, PBIP, and a partially capitated comprehensive primary care payment (CPCP). The CPCP provides a specified percentage of each Track 2 practice's expected E&M revenue in lump sum, quarterly payments and discounts the fee-for-service (FFS) payments to the provider over the course of the year.

Beginning in 2023, the MDPCP will add a new Track 3 that is open to nonhospital-based primary care practices and their partner CTO, if any; FQHCs cannot participate in Track 3. Track 3 builds on lessons learned from MDPCP Tracks 1 and 2 and the Primary Care First (PCF) Model, as well as stakeholder feedback from current MDPCP participants and the State's Program Management Office (PMO). Track 3 is modeled after and adapted from the PCF model, and further aligns with the goals of the Total Cost of Care (TCOC) Model to test whether population-based payments, in conjunction with State-wide health care delivery transformation, improve population health and care outcomes for individuals, while controlling the growth of Medicare TCOC. Participants in Track 3 do not receive a CMF, PBIP, or CPCP; rather, they receive a prospective, population-based payment (PBP), paid quarterly; a Flat Visit Fee (FVF) paid at the time of service for certain primary care

services; and a Performance-Based Adjustment (PBA) applied to the PBP and FVF that is based on performance on certain quality, utilization, and efficiency measures. The PBP and PBA shall be processed outside the fee for service claims processing system and are not addressed in this CR.

B. Policy: These Track 3 participants will receive a combination of claims and non-claims-based payments based on their attributed Medicare fee-for-service (FFS) beneficiaries. With fewer reporting requirements, Track 3 practices will have the flexibility to implement their own strategies that best target outcomes.

Participants in the MDPCP are primary care practices within the state of Maryland. A primary care practice may include one or more physicians, as well as non-physician providers such as nurse practitioners. Every participating practice will be given a unique practice ID by the CMS implementation support contractor. Providers in a practice will be uniquely defined by the combination of each provider's tax ID number (TIN) and national provider identifier (NPI).

Track 3 will begin operation on January 1, 2023. Current and new MDPCP participants will have the option to participate in Track 3 from that date through December 31, 2026. CMS will create a provider file that lists all participating providers and the effective and termination dates of their participation in MDPCP Track 3. A given provider (as defined by the combination of TIN and NPI) may only be active in one MDPCP practice at a time. Providers within a practice may have different effective and termination dates (e.g., as they are hired or leave the practice), but the practice itself will have its own effective and termination date for participation in the model. CMS will also create a beneficiary file detailing all attributed (which is also referred to as aligned) Medicare FFS beneficiaries to participants in MDPCP Track 3. Please note this MDPCP Track 3 CR is a follow-on to the Analysis and Design CR 12556 and addresses the following objectives for the January 2023 Release.

- Flat Visit Fee (FVF) HCPCS codes detailed in Appendix A
- Prohibited Healthcare Common Procedure Coding System (HCPCS) codes detailed in Appendix B

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	
12837.1	The CMS specialty/operations contractor shall send the Multi-Carrier System (MCS) the initial provider participant files detailing Maryland Primary Care Program (MDPCP) participating providers on a quarterly basis. . **NOTE**: The provider participant file will be a national									CMS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	file accessible by all Medicare Administrative Contractors (MACs). The CMS operations contractor contacts are: Samuel Masters (Samuel.Masters@lewin.com); Sunitha Siddaramu (sunitha.siddaramu@lewin.com); SIGMulti-PayerOPs@Lewin.com									
12837.2	The CMS specialty/operations contractor shall send MCS the initial beneficiary alignment files detailing beneficiaries aligned to the MDPCP participating providers on a quarterly basis. . **NOTE**: The beneficiary alignment file will be a national file accessible by all MACs. The CMS operations contractor contacts are: Samuel Masters (Samuel.Masters@lewin.com); Sunitha Siddaramu (sunitha.siddaramu@lewin.com); SIGMulti-PayerOPs@Lewin.com									CMS
12837.3	The CMS specialty/operations contractor shall use the file layouts identified in Appendices D/C/E for the provider participant file, beneficiary participant file, and the response files.									CMS
12837.4	MCS shall accept the beneficiary and provider file layouts for the MDPCP processing changes.						X			
12837.5	Contractors shall maintain an update date in their internal file that will reflect the date the updated files were loaded into the shared system. **NOTE:** The field shall be viewable to the MACs.						X			
12837.6	The CMS specialty/operations contractor shall deliver the provider participant and beneficiary alignment files to the Virtual Data Centers (VDCs) when they become available. **NOTE:** Business Requirements (BRs) shall be									CMS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	applicable to all test files.									
12837.6.1	The CMS specialty/operations contractor shall transmit the provider participant and beneficiary alignment files through electronic file transfer (EFT).									CMS
12837.6.2	The CMS specialty/operations contractor shall notify the contractors of the provider participant and beneficiary alignment file names when they become available.									CMS
12837.7	The Shared Systems shall create response files acknowledging receipt of the provider participant and beneficiary alignment files.						X			
12837.7.1	Contractors shall perform limited editing to ensure the file is well-formed. The validation checks will include: • the Header Record must be present and fields populated with valid information; • the Trailer Record must be present and fields populated with valid information; and the actual count of detail records must match the count in the Trailer Record.						X			
12837.7.2	Contractors shall produce a response file that indicates the file was processed and contained no errors, if no validation errors were encountered.						X			
12837.7.3	If validation errors are encountered, the Contractors shall produce a response file that indicates specific records and fields that did not pass the validation checks using error codes defined in response file (Appendix E).						X			
12837.8	The CMS specialty/operations contractor shall provide the initial provider participant and beneficiary alignment testing files to the VDCs on or a few days after 12/5/22 so the test data can become available in UAT for the contractor. The CMS specialty/operations contractor shall transmit the provider participant and beneficiary alignment files through electronic file									CMS, MIST, VDC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	transfer (EFT). The CMS operations contractor contacts are: Samuel Masters (Samuel.Masters@lewin.com); Sunitha Siddaramu (sunitha.siddaramu@lewin.com); SIGMulti-PayerOPs@Lewin.com									
12837.8.1	The VDCs shall run the jobs to load the test files.									VDC
12837.9	The CMS specialty/operations contractor shall transmit the provider participant and beneficiary alignment files through electronic file transfer (EFT).									CMS
12837.10	The CMS specialty/operations contractor shall deliver the initial provider participant and beneficiary alignment production files via electronic file transfer (EFT) to the VDC no later than 12/28/2022.									CMS
12837.10.1	The VDCs shall run the jobs to load the production files after the release is fully implemented.									VDC
12837.10.2	The VDCs shall make available to the contractors testing environments for the provider participant and beneficiary alignment files.									VDC
12837.10.3	The Medicare Integrated Systems Testing (MIST) shall perform testing on the provider participant and beneficiary alignment files, working with the VDCs as necessary to obtain the file. **NOTE:** The MIST shall send sample test data by 9/01/2022 to the specialty/operations contractor contacts: Samuel Masters (Samuel.Masters@lewin.com); Sunitha Siddaramu (sunitha.siddaramu@lewin.com); SIGMulti-PayerOPs@Lewin.com These samples of providers and beneficiaries shall include a list of 5 to 15 test Health Insurance Claim Numbers (HICNs), Tax Identification Numbers (TINs), and National Provider Identifiers (NPIs) in a single Comma Separated Value (CSV) file using a									MIST, VDC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	HICN, TIN, and NPI layout. MIST shall begin testing on 11/07/2022.									
12837.10.4	To assist with the testing files creation, the contractors shall provide the CMS specialty/operations contractor the beneficiary and participant (provider) data to create test files by 9/1/22. These samples of providers and beneficiaries shall include a list of 5 to 15 test Health Insurance Claim Numbers (HICNs), Tax Identification Numbers (TINs), and National Provider Identifiers (NPIs) in a single Comma Separated Value (CSV) file using a HICN, TIN, and NPI layout. The sample data shall be sent to the CMS specialty/operations contractor contacts: Samuel Masters (Samuel.Masters@lewin.com); Sunitha Siddaramu (sunitha.siddaramu@lewin.com); SIGMulti-PayerOPs@Lewin.com The CMS specialty/operations contractor shall provide a template of this CSV file.									JL A/B MAC, MIST, RRB-SMAC
12837.10.5	The CMS specialty/operations contractor shall push the test beneficiary alignment and provider participant files to the Virtual Data Centers (VDCs) no later than 9/9/22, and transmit these test files with the Part B MACs. CMS Specialty/Operations Contractor Contacts: Samuel Masters (Samuel.Masters@lewin.com); Sunitha Siddaramu (sunitha.siddaramu@lewin.com); SIGMulti-PayerOPs@Lewin.com									CMS
12837.10.6	MCS shall receive a test file from the CMS specialty contractor no later than the ALPHA testing time frame. CMS Specialty/Operations Contractor Contacts: Samuel Masters (Samuel.Masters@lewin.com); Sunitha Siddaramu (sunitha.siddaramu@lewin.com); SIGMulti-PayerOPs@Lewin.com									CMS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12837.11	After the initial production provider participant and beneficiary alignment file transmission, the CMS operations/specialty contractor shall provide full replacement participant and beneficiary files as needed.									CMS
12837.12	The VDCs shall transmit the provider participant and beneficiary alignment file response via electronic file transfer (EFT) for all test and production files to the CMS specialty/operations contractor.									VDC
12837.13	The CMS specialty/operations contractor shall provide a list of Flat Visit Fee (FVF) services covered under the MDPCP Track 3 in a file labeled "Appendix A."									CMS
12837.13.1	The CMS specialty/operations contractor shall provide a list of prohibited services under the MDPCP Track 3 in a file labeled "Appendix B."									CMS
12837.14	Contractors shall use the following messages for claim lines processed and paid in accordance with the rules of MDPCP Track 3, unless otherwise specified in this CR: Claim Adjustment Reason Code (CARC) 132: "Prearranged demonstration project adjustment" Group Code: CO (Contractual Obligation) MSN 60.4: This claim is being processed under a demonstration project. Spanish Translation: Esta reclamación está siendo procesada bajo un proyecto especial.						X			JL A/B MAC, RRB-SMAC
12837.15	Contractors shall apply beneficiary cost-sharing based on traditional FFS rules for Appendix A procedures.						X			JL A/B MAC, RRB-SMAC
12837.16	MCS shall apply demonstration code “A4” for MDPCP Track 3 of the MDPCP to professional claims submitted on the CMS-1500 (or electronic equivalent) where:						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• The beneficiary HIC Number (HICN) number, and billing provider Tax Identification Number (TIN) match those listed in the beneficiary file; and • The billing provider TIN and rendering NPI match those listed on the MDPCP Track 3 provider participant file; and • The MDPCP Identifier (MDPCP Practice ID) from the beneficiary file for the identified Insured's I.D. Number matches the MDPCP Practice ID corresponding to the identified participant record; and • The date of service for the detail line is between the effective start date and end date (inclusive) for the matching records in the beneficiary alignment and provider participant files; and • Medicare is the primary payer for the service. AND Once the following situations reflect the HCPCS codes billed on the claim line: • The HCPCS code listed on the detail line is one of the eligible codes listed in Appendix A or B of this CR; and • The detail date of service is within the effective and end date for the Appendix A or B HCPCS code.									
12837.17	CMS shall use the provider and beneficiary file layouts as defined in Appendices D and C.									CMS
12837.18	Contractors shall reject or return as unprocessable claim lines that contain HCPCS codes listed in Appendix B and shall use the messages below: CARC: 96 “Non-covered charge(s).” Remittance Advice Remark Code (RARC): N83 “No						X			JL A/B MAC, RRB-SMAC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	appeal rights. Adjudicative decision based on the provisions of a demonstration project." Group Code: CO									
12837.19	CMS shall issue guidance in a Technical Direction Letter (TDL) in the event any changes made to Appendices A and B subsequent to the release of this CR. **Note:** CMS anticipates any changes made to Appendices A and B shall only occur on an annual basis. The CMS operations contractor contacts are: Samuel Masters (Samuel.Masters@lewin.com); Sunitha Siddaramu (sunitha.siddaramu@lewin.com); SIGMulti-PayerOPs@Lewin.com									CMS
12837.20	MCS shall plug demonstration code "A4" to the first blank demonstration code field, if at least one claim detail line meets the Track 3 criteria. **Note:** If multiple demo codes are on a claim demo, "A4" should come after all other demo codes.						X			
12837.20.1	Contractors shall recognize, accept, and/or use demo code A4: MDPCP Track 3 of the MDPCP									HIGLAS
12837.21	The CMS specialty/operations contractor shall provide a list of FVF services covered under the MDPCP Track 3 in a file labeled "Appendix A."									CMS
12837.21.1	MCS shall use the FVF value as the provider paid amount, before MIPS and sequestration, for payable FVF detail procedures.						X			
12837.22	MCS shall add claim processing logic to apply the FVF detail line allowed amount from the Medicare Physician Fee Schedule Data Base (MPFSDB) file in either field 31AA Facility Imaging Payment Amount or 31BB Non-facility Imaging Payment Amount to impacted claims subject to the FVF. MCS shall use						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	existing processing logic to determine whether to use the facility or non-facility FVF.									
12837.23	Contractors shall manually add the FVFs to the MPFS facility and non-facility imaging payment amount fields for procedure codes listed in Appendix A using the FVFs provided in a TDL. NOTE: CMS will instruct the MACs on future updates to the fees via a TDL.									CMS, JL A/B MAC, RRB-SMAC
12837.24	Contractors shall return as unprocessable an incoming claim if the provider appends a demonstration code of "A4" on the CMS-1500 (or electronic equivalent). Contractors shall use the following message: CARC: 132 “Prearranged demonstration project adjustment.” Group Code: CO						X			JL A/B MAC, RRB-SMAC
12837.25	A/B MACs Part B shall refer all provider inquiries regarding claims and/or claim lines subject to the rules of the MDPCP to the MDPCP Help Desk. Below are the contact details for the MDPCP Help Desk: MarylandModel@cms.hhs.gov Help Desk Phone Number: 1-844-711-2664; Option 7									JL A/B MAC, RRB-SMAC
12837.26	MCS shall not apply the non-physician provider (NPP) reduction to the following: All claim details subject to the FVF with dates of service on or after January 1, 2023						X			
12837.27	Beneficiary liabilities (coinsurance/deductible) for FVF details otherwise subject to the NPP reduction, shall be calculated as they would have been under the traditional Medicare FFS program. That is, passing this reduction shall not result in an increase in beneficiary liability under the model.						X			JL A/B MAC, RRB-SMAC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12837.28	Contractors shall process non-MDPCP claim lines as normal FFS when billed on the same claim as MDPCP claim lines.						X		X	JL A/B MAC, RRB-SMAC
12837.29	Contractors shall allow more than one paid MDPCP FVF visit per beneficiary per date of service. If more than one FVF HCPCS codes are billed on the same claim for the same date of service processed as a demo "A4" claim, MCS shall validate and apply the FVF for all the FVF-eligible HCPCS codes listed in Appendix A.						X			JL A/B MAC, RRB-SMAC
12837.30	Coinsurance and deductible shall be calculated the same as they would have been under traditional Medicare FFS.						X			JL A/B MAC, RRB-SMAC
12837.31	For claims subject to the MDPCP Track 3 FVF adjustment, MCS shall include on the CWF claim transmission record (HUBC) the adjustment amount attributable to each line in the "Other Amounts Applied" field, using the following: • The Other Amount Indicator 'A2' to indicate the amount by which each line was reduced for the FVF adjustment. • The Other Amount Indicator 'A3' to indicate the amount by which each line was increased for the FVF adjustment.						X			
12837.32	CWF shall allow an Other Amount Indicator of 'A2' and/or 'A3' for claims with dates of service on or after implementation. CWF shall ensure that edits '92x5' and '97x1' will not set on Part B MDPCP claims when 'A2' or 'A3' is present in the OA Indicator field.								X	
12837.33	CWF shall allow an Other Amount Indicator of 'A2' and/or 'A3' for claims with dates of service on or after implementation. CWF shall ensure that edits '92x5' and '97x1' will not set on Part B MDPCP claims when 'A2' or 'A3' is present in the OA Indicator field.								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12837.34	For claims subject to the MDPCP Track 3 FVF adjustment, MCS shall include on the CWF claim transmission record (HUBC) the adjustment amount attributable to each line in the "Other Amounts Applied" field, using the following: • The Other Amount Indicator 'A2' to indicate the amount by which each line was reduced for the FVF adjustment. • The Other Amount Indicator 'A3' to indicate the amount by which each line was increased for the FVF adjustment.								X	
12837.35	CWF shall ensure that Part B consistency edit '97x1' does not set when Other Amount Indicator 'A2' or 'A3' is received on MDPCP Track 3 claims.								X	
12837.36	Contractors shall send the new MDPCP demo code, Other Amount Indicator, and payment adjustment amount to the IDR claims file.						X			IDR, JL A/B MAC, RRB-SMAC
12837.37	MCS shall process all Medicare secondary payer claims as normal FFS claims.						X			
12837.38	Contractors shall subject MDPCP claims to sequestration, MIPS, and any other adjustments that the claim line would otherwise be subject to unless otherwise specified in this CR.						X			JL A/B MAC, RRB-SMAC
12837.39	MCS shall create an IUR if a beneficiary alignment record file identifies a claim in history with demonstration code "A4" and dates of service are no longer during the beneficiary alignment period.						X			JL A/B MAC, RRB-SMAC
12837.40	MCS shall create an IUR if a beneficiary alignment record file identifies a claim in history without demonstration code "A4" and dates of service are during the beneficiary alignment period.						X			JL A/B MAC, RRB-SMAC
12837.41	MCS shall create an IUR if a provider participant record file identifies a claim in history with demonstration code "A4" and the dates of service are						X			JL A/B MAC, RRB-SMAC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	no longer during the provider participant period.									
12837.42	MCS shall create an IUR if a provider participant record file identifies a claim in history without demonstration code "A4" and the dates of service are during the provider participant period.						X			JL A/B MAC, RRB-SMAC
12837.43	CWF shall modify Part B consistency edit '0014' in HUBCCED to accept demonstration code "A4". Error Message: '0014'								X	
12837.44	CWF shall ensure that demonstration code "A4" is carried to the claim history and transmitted to the National Claims History (NCH) file when present on HUBC claims.								X	NCH
12837.45	The contractors shall process MDPCP Track 3 Overpayment with Shared System Reason Code 'O' **Note:** The contractors shall use any of the existing Discovery Codes based on the determination if CMS, MAC, or Provider initiated the overpayment.									JL A/B MAC, RRB-SMAC
12837.46	Contractors shall handle all MDPCP model claims and/or claim lines as non-935 eligible. **Note: MDPCP claims and/or claim lines are not eligible for 935 appeal rights**						X			JL A/B MAC, RRB-SMAC
12837.47	The contractors shall use an appropriate Discovery Code and Reason Code 'O' when initiating the MDPCP overpayment adjustments.									JL A/B MAC, RRB-SMAC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility		
		A/B MAC	DME	CED

		A	B	H H H	M A C	I
	None					

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Adrienne Wiley, adrienne.wiley@cms.hhs.gov , Sarah Miouduski, Sarah.Mioduski@cms.hhs.gov

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: 5

Appendix A: Track 3 FVF HCPCS Code List

HCPCS Codes	Service Type
99202	Office/Outpatient Visit E/M
99203	Office/Outpatient Visit E/M
99204	Office/Outpatient Visit E/M
99205	Office/Outpatient Visit E/M
99211	Office/Outpatient Visit E/M
99212	Office/Outpatient Visit E/M
99213	Office/Outpatient Visit E/M
99214	Office/Outpatient Visit E/M
99215	Office/Outpatient Visit E/M
99354	Prolonged Service with Direct Patient Contact
99355	Prolonged Service with Direct Patient Contact
99417	Prolonged E/M
99421	Digital E/M
99422	Digital E/M
99423	Digital E/M
99441	Telephone E/M
99442	Telephone E/M
99443	Telephone E/M
99453	Remote Patient Monitoring
99454	Remote Patient Monitoring

G2010	Virtual Check-in
G2012	Virtual Check-in
G2212	Prolonged E/M

Appendix B: Prohibited HCPCS Codes

Prohibited HCPCS Codes	HCPCS Codes Service Type
99339	Home Care
99340	Home Care
99490	CCM Services
99491	CCM Services
G0511	CCM Services
99487	Complex CCM services
99489	Complex CCM services
G0506	Assessment/care planning for patients requiring CCM services
G2058	Non-complex CCM clinical staff time
99439	Non-complex CCM clinical staff time
G2064	CCM services for a single high-risk disease (Principal Care Management or PCM)
G2065	CCM services for a single high-risk disease (Principal Care Management or PCM)
99358	Prolonged non-face-to-face evaluation and management (E&M) services
99359	Prolonged non-face-to-face evaluation and management (E&M) services
99457	Remote Physiologic Monitoring Treatment Management Services (RPM), Development and management of a plan of treatment based upon patient physiologic data
99458	Remote Physiologic Monitoring Treatment Management Services (RPM), Development and management of a plan of treatment based upon patient physiologic data
99484	Management of behavioral health conditions(s), timed, per month

99492	Management of behavioral health conditions(s), timed, per month
99493	Management of behavioral health conditions(s), timed, per month
99494	Management of behavioral health conditions(s), timed, per month
G2214	Management of behavioral health conditions(s), timed, per month
99446	Interprofessional Consultation
99447	Interprofessional Consultation
99448	Interprofessional Consultation
99449	Interprofessional Consultation
99451	Interprofessional Consultation
99452	Interprofessional Consultation
99483	Assessment of and care planning for a patient with cognitive impairment
G3002	Chronic Pain Management
G3003	Chronic Pain Management

Appendix C: Beneficiary Alignment File Layout

Header record consisting of:

Record Identifier - 11 Positions - Alpha numeric, Value = "MP3-BEN-HDR"

File Creation Date - 8 Positions - CCYYMMDD Format

Filler - 38 Positions – Spaces

Detail records consisting of:

Record Identifier - 11 Positions - Alphanumeric, Value = "MP3-BEN-DTL"

MDPCP Model Identifier - 9 Positions - Alphanumeric = "T#MD####"

Participant Tax Identification Number (TIN) - 9 Positions – Numeric

HICN - 12 Positions – Alphanumeric

Participant Effective Start Date - 8 Positions - CCYYMMDD Format

Participant End Date - 8 Positions - CCYYMMDD Format

Trailer record consisting of:

Record Identifier - 11 Positions - Alphanumeric, Value "MP3-BEN-TRL"

Detail Record Count - 10 Positions – Numeric

Filler - 36 Positions - Spaces

Appendix D: Provider Alignment File Layout

Header record consisting of:

Record Identifier - 11 Positions - Alpha numeric, Value = "MP3-PRV-HDR"

File Creation Date - 8 Positions - CCYYMMDD Format

Filler - 38 Positions – Spaces

Detail records consisting of:

Record Identifier - 11 Positions - Alphanumeric, Value = "MP3-PRV-DTL"

MDPCP Model Identifier - 9 Positions - Alphanumeric = "T#MD####"

Participant Tax Identification Number (TIN) - 9 Positions – Numeric

Participant National Provider Identifier (NPI) - 10 Positions – Numeric

Adjustment Percentage - 2 Positions – Numeric

Participant Effective Start Date - 8 Positions - CCYYMMDD Format

Participant End Date - 8 Positions - CCYYMMDD Format

Trailer record consisting of:

Record Identifier - 11 Positions - Alphanumeric, Value "MP3-PRV-TRL"

Detail Record Count - 10 Positions – Numeric

Filler - 36 Positions - Spaces

Appendix E: Response File Layout & Error Codes

PROVIDER ALIGNMENT FILE RESPONSE FILE LAYOUT

Header record consisting of:

Record Identifier - 11 Positions - Alphanumeric, Value = ''MP3-PRV-HDR"

Response Code - 2 Positions - Numeric

File Creation Date - 8 Positions - CCYYMMD Format

Detail records consisting of:

Record Identifier - 11 Positions - Alphanumeric, Value "MP3-PRV-DTL"

Detail Response Code - 2 Positions – Numeric

MDPCP Model Identifier - 10 Positions – Alphanumeric

Participant Tax Identification Number (TIN) - 9 Positions – Numeric

Participant National Provider Identifier (NPI) - 10 Positions – Numeric

Participant Effective Start Date - 8 Positions CCYYMMDD Format

Participant Effect End Date - 8 Positions - CCYYMMDD Format

Trailer record consisting of:

Record Identifier - 11 Positions - Alphanumeric, Value "MP3-PRV-TRL"

Trailer Level Response Code - 2 Positions – Numeric

Detail Record Count - 10 Positions – Numeric

BENEFICIARY ALIGNMENT FILE RESPONSE FILE LAYOUT

A header record consisting of:

Record Identifier - 11 Positions – Alphanumeric

Header Level Response Code - 2 Positions – Numeric

File Creation Date - 8 Positions - CCYYMMDD Format

Detail records consisting of:

Record Identifier - 11 Positions – Alphanumeric.

Detail Response Code - 2 Positions – Numeric.

Maryland Comprehensive Primary Care Model Identifier - 9 Positions – Alphanumeric.

Participating Tax Identification Number (TIN) - 9 Positions – Numeric

Beneficiary HICN – 12 Positions – Alphanumeric

Effective Start Date in the Maryland Comprehensive Primary Care Model - 8 Positions - CCYYMMDD Format

Effective End Date in the Maryland Comprehensive Primary Care Model - 8 Positions - CCYYMMDD Format

Trailer record consisting of:

Record Identifier - 11 Positions – Alphanumeric

Trailer Level Response Code - 2 Positions – Numeric

Detail Record Count - 10 Positions – Numeric

Validation Check Error Codes

00 = Success - The record passed all validation editing.

01 = Invalid Record Identifier

10 = Header Record missing or not found as the first record in the file

11 = Header Record date error

20 = TIN not numeric or TIN format error

21 = TIN not found on the National Provider Master file (RRB master file)

22 = NPI format error

23 = HICN format error

24 = Invalid Effective Start Date

25 = Invalid Effective End Date

26 = Adjustment Percentage error

30 = Trailer Record missing

32 = Trailer Record count error