CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-19 Demonstrations	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12365	**Date: November 16, 2023**
	Change Request 13412

SUBJECT: Guiding an Improved Dementia Experience (GUIDE) Model Implementation

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to implement the GUIDE Model, a demonstration testing alternative payment models and support for people with dementia and their caregivers.

EFFECTIVE DATE: April 1, 2024 - Analysis, Design and Coding; July 1, 2024 - Testing and Implementation
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 1, 2024 - Analysis, Design and Coding; July 1, 2024 - Completion of Coding, Testing and Implementation

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: 12365	Date: November 16, 2023	Change Request: 13412

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I. GENERAL INFORMATION

A. Background: Section 1115A of the Social Security Act (the Act) establishes the Center for Medicare and Medicaid Innovation (the Innovation Center) for the purpose of testing innovative payment and service delivery models to reduce Medicare and Medicaid expenditures while preserving or enhancing the quality of care furnished to beneficiaries of such programs. Executive Order 14095 of April 18, 2023, on Increasing Access to High-Quality Care and Supporting Caregivers, directed the Secretary of Health and Human Services to "consider whether to select for testing by the Innovation Center an innovative new health care payment and service delivery model focused on dementia care that would include family caregiver supports such as respite care."

Consistent with its statutory mandate and the Executive Order on supporting caregivers, the Innovation Center is seeking to test an alternative payment model for Medicare Fee-for-Service (FFS) beneficiaries with dementia. Through the model, CMS aims to promote a broad package of care management and coordination, caregiver education and support, and respite services. The model is designed to reduce Medicare and Medicaid expenditures primarily by reducing long-term nursing home care, and secondarily by reducing hospital, emergency department, and post-acute care utilization. The model is designed to enhance quality of care by improving quality of life for people with dementia and reducing burden and strain on their caregivers. We expect that reducing caregiver burden will also enhance quality of life for the beneficiaries to whom they are providing care.

GUIDE will be an 8-year voluntary national model that may be offered in all states, U.S. territories, and the District of Columbia. Eligible providers and suppliers will apply for participation in GUIDE. Target participation is 600 model participants, each with an expected average of 200 voluntarily aligned Medicare FFS beneficiaries, including beneficiaries dually eligible for Medicare and Medicaid. New participants and providers may be added and removed throughout the model and CMS will provide updated files of participants and providers as well as attributed beneficiaries monthly.

The model will pay participants a Per Beneficiary Per Month (PBPM) amount, known as a Dementia Care Management Payment (DCMP), for providing care management and coordination and caregiver education and support services to beneficiaries and caregivers. DCMP rates will be adjusted by a Health Equity Adjustment (HEA) and a Performance Based Adjustment (PBA) to incentivize high-quality care. The HEA and PBA adjustments will not begin until the second Performance Year (PY2).

GUIDE will also pay for a defined amount of respite services for a subset of model beneficiaries. Model participants will use a set of new G-codes created for the GUIDE model to submit claims for the monthly DCMP and the respite codes. Each model tier will have a different DCMP rate to reflect the fact that covered

services and care intensity will vary across the tiers.

Participants will bill respite services on an ad hoc basis, for certain eligible beneficiaries in the model paid up to an annual cap of $2,500 per beneficiary per year. The allowed billing amount for these three respite G-codes will be 0. Outside of the claims system, the Innovation Payment Contractor (IPC) will handle the payment of these non-claims-based payments. In addition to claims-based payments, participating providers may receive one upfront infrastructure payment. This infrastructure payment and tracking of the respite cap shall be processed separately from the claims system and are not addressed in this CR.

B. Policy: GUIDE participants will be required to bill all GUIDE-specific G-codes, including both the DCMP and respite care G-codes, on a standalone claim with no other Healthcare Common Procedure Coding System (HCPCS) codes. All DCMP claims must include a diagnosis code listed in Appendix D. The GUIDE demonstration code (A6) should only be added to a claim that has GUIDE-specific G-codes. If a claim comes in with a GUIDE code and other codes, this claim should be unprocessable and sent back to the participant for resubmission. The GUIDE demonstration code will not be placed on non-GUIDE specific claims in any position. GUIDE participants shall continue to bill HCPCS codes for all other services on other claims as they normally do under the traditional Medicare program. Normal FFS detail lines, in addition to, any other demo codes and demonstration detail lines should never be on a GUIDE Model claim. GUIDE Model claims are standalone claims. Only detail lines with HCPCS from Appendix A and B should be on GUIDE Model claims.

The beneficiary attribution process will be conducted outside of the claims system although a list of beneficiaries attributed to the model shall be provided to contractors for the purposes of claims adjudication every month. Patient coinsurance and deductible are waived for the GUIDE Model. Occasionally, claims are incorrectly processed in models, and GUIDE participating providers and beneficiaries may retroactively be added or removed. In this case, there will be a retroactive effective date. Systems should go back and reprocess the claim, adding or removing payments as necessary based on the track.

Except as otherwise specified, GUIDE claims shall be subject to all other adjustments (e.g. sequestration) and policies applicable to other fee for service claims. For the GUIDE DCMP code to be eligible, shared systems should check the beneficiary attribution and provider alignment files for eligibility.

Criteria for DCMP claims:

- *Claim is for a beneficiary included in the GUIDE beneficiary alignment file, identified by Health Insurance Claim Number (HICN) or Medicare Beneficiary Identifier (MBI)*
- *Claim is an appropriate Date of Service (DOS) for beneficiary attribution dates*
- *The participant only billed for the DCMP once per calendar month for that beneficiary*
- *Tax Identification Number (TIN) and National Provider Identifier (NPI) are both included in provider alignment file*
- *The claim includes a diagnosis code provided in Appendix D*

Criteria for respite claims:

- *Claim is for a beneficiary included in the GUIDE beneficiary alignment file, identified by HICN or MBI and eligible for respite*
- *TIN and NPI are both included in provider alignment file*
- *The claim includes a diagnosis code provided in Appendix D*
- *Only beneficiaries in certain model tiers will be eligible for respite services*

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	
13412.1	Contractors shall prepare their systems to accept and process GUIDE Model claims for DOS on or after July 1, 2024.		X				X		X	
13412.2	Contractors shall use Demonstration (demo) code ‘A6’ to identify GUIDE Model claims.						X		X	HIGLAS
13412.2.1	The Contractors shall modify Consistency Edit '0014' to include Demo Code 'A6' as a valid Demo Code effective for Dates of Services on or after July 1, 2024 for Part B Claims.								X	
13412.2.2	Contractors shall ensure demo code ‘A6’ and ACO ID that begins with (‘G’) and flow to downstream systems National Claims History (NCH) and the Integrated Data Repository (IDR).						X		X	IDR, NCH
13412.3	The contractor shall append demo code ‘A6' as GUIDE Model claims under the following conditions: • Present on the detail line is one of the Current Procedural Terminology CPT/HCPCS codes listed in Appendix A and B; and • The claim includes an aligned provider (the rendering provider TIN/NPI is found on the provider alignment file with a GUIDE Model Identifier (‘G’)); and • The claim includes an aligned beneficiary (the beneficiary HICN is present on the beneficiary alignment file, with the same GUIDE Model Identifier (‘G’) as the rendering provider); and • The DOS is on or within the Effective Start and End Dates on both the provider participant and beneficiary alignment records. • The claim includes a diagnosis code provided in Appendix D.						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13412.4	The contractor shall not apply demo code ‘A6’ when another demo code(s) is already appended to the claim or if any other demo code(s) applies to the claim.						X			
13412.5	The contractor shall accept and process GUIDE Model respite care service detail lines, which meet the criteria outlined in Business Requirement (BR) 13412.3, as a “no pay” detail line. **NOTE:** The allowed amount for any respite care service (Appendix B) under the GUIDE Model shall be ‘0’.						X		X	
13412.5.1	Contractors shall use the following messages for GUIDE Model “no pay” respite services. • Claim Adjustment Reason Code (CARC): 132 - “Prearranged demonstration project adjustment.” • Group Code: Contractual Obligation (CO) • Remittance Advice Remark Code (RARC): N83 - "No appeal rights. Adjudicative decision based on the provisions of a demonstration project." • Medicare Summary Notice (MSN) Message: 60.4 - “This claim is being processed under a demonstration project.” • Spanish Translation: “Esta reclamación está siendo procesada bajo un proyectoprojecto especial.”		X				X			
13412.5.2	Contractors shall create a new monthly report for ‘no pay’ respite care services and include the following information: • Billing Provider Transaction Access Number (PTAN) • Billing Provider NPI • Rendering Provider PTAN • Rendering Provider NPI						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• Beneficiary MBI • Beneficiary HICN • Contractor number • Internal Control Number (ICN) • ICN Paid Date • ICN Claim Detail Information • Dates of Service • Number of Services • Procedure Code **NOTE**: The report shall be sent via the CSRS application.									
13412.5.3	The contractor shall waive coinsurance and deductible for all GUIDE Model claims that meet the criteria listed in BR 13412.3.		X							
13412.6	CMS shall send the contractors the initial provider participant and beneficiary alignment files for the GUIDE Model.						X		X	
13412.6.1	To assist with the creation of the provider and beneficiary alignment test file, the contractor shall provide CMS with data to create test files by April 12, 2024 to the CMS contacts listed below. These samples of providers and beneficiaries shall include a list of 5 to 15 test HICNs/MBIs in a single Comma Separated Value (CSV) file. CMS contacts: Charlotte Kaye, charlotte.kaye1@cms.hhs.gov Sage Hart, sage.hart@cms.hhs.gov. NOTE: After the initial test file, the MACs will use the MCS Model Test Data Entry (MTDE) application to update/create test GUIDE Model provider alignment records.		X							CMS
13412.6.2	The contractors shall accept the file layouts to support						X		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	
	the GUIDE Model processing changes.									
13412.6.2.1	The contractor shall update the standard beneficiary alignment record and the Cloud Storage and Retrieval System (CSRS) application to support the addition of the following fields to the end of the record: • Beneficiary Model Tier • HEA Amount • Respite Eligibility Indicator						X			
13412.6.2.1.1	The contractor shall modify online screens to display the new beneficiary model tier indicator, HEA amount, and Respite Eligibility Indicator on the beneficiary alignment record.						X			
13412.6.2.2	The contractor shall update the MTDE application for the GUIDE Model provider participant file.						X			
13412.6.3	The contractor shall perform testing by creating test files using ICD supplied file formats. MIST shall begin testing on or about May 6, 2024. **NOTE:** The CSRS application is not connected to the MIST test region.									MIST
13412.7	CMS shall upload the production provider participant and beneficiary alignment files in the CSRS application on or about June 28, 2024, in place for the July Release implementation.									CMS
13412.7.1	After the initial production files, contractors shall update their systems and process the files as full replacement files.						X		X	
13412.7.1.1	CMS shall provide the provider participant and beneficiary alignment files on a monthly basis.									CMS
13412.8	Contractors shall modify the current response files or create new response files to acknowledge receipt of the GUIDE provider participant and beneficiary						X		X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	alignment files. **NOTE:** The ICD will define the response file layout.									
13412.8.1	The contractor shall send a response file generated from a CWF Utility that will contain a Header record, Detail record(s) and a Trailer record. **NOTE:** File length is 55 bytes per Header/Detail/Trailer.								X	
13412.9	Contractors shall perform limited validation to ensure the file is well formed. The validation checks shall include: • the Header Record must be present and fields populated with valid information; and • 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		X	MIST
13412.10	The contractor shall add GUIDE Model beneficiary data to the ACOB Auxiliary File viewable within the HIMR with the following data elements included: • Record Identifier • GUIDE ID Number = ##### • Beneficiary HICN • Beneficiary Start Date • Beneficiary Termination Date • Delete Flag (Value D or space) • Beneficiary Host ID • Gender • Medical Data sharing preference **NOTE:** The value indicating a GUIDE Beneficiary on the ACOB Auxiliary file is G = GUIDE.								X	
13412.11	The contractor shall modify the beneficiary alignment output file with the most current HICN to be provided						X		X	VDC

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	
	to the Virtual Data Centers (VDCs) for the Multi-Carrier System (MCS) to receive.									
13412.12	Contractors shall maintain an update date in their internal file to capture any updates made to the provider participant and beneficiary alignment files.						X		X	
13412.13	The contractor shall adjust claims that are: • processed as GUIDE and the provider is no longer active for the claim's date of service; or • not processed as GUIDE when the provider is active for the claim's date of service.						X			
13412.13.1	Contractors shall make table/file updates to create a new adjustment reason code for overpayments identified under Guiding an Improved Dementia Experience (GUIDE) Model. 37 - Overpayment Identified under Guiding an Improved Dementia Experience (GUIDE) Model		X							HIGLAS
13412.13.2	The contractors shall map the Shared System Reason code '37' to the HIGLAS Reason Code '37' for Part B Orgs.									HIGLAS
13412.13.3	Contractors shall use the Reason Code '37' and existing Discovery Code 'C' when initiating the GUIDE model adjustments for the recoupment of overpayments.		X							
13412.13.4	Contractors shall follow the normal non-935 recoupment process for these adjustments.		X							HIGLAS
13412.13.5	Contractors shall ensure the 935 Indicator is not set (i.e., set the 935 Indicator to 'N' for these adjustments as they are not eligible for the Section 935 appeal rights).		X							
13412.13.6	Contractors shall use the following verbiage for the 'Reason for Overpayment' in the provider (Part B) demand letter enclosure for the new HIGLAS Reason									HIGLAS

Number	Requirement	Responsibility								
		A/B MAC			D M E MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	code '37': ‘Per the Guiding an Improved Dementia Experience (GUIDE) Model billing rules, this payment was made to you in error.’									
13412.13.7	Contractors shall use the following verbiage for the 'Reason for Overpayment' in the beneficiary (Part B) demand letter enclosure for the new HIGLAS Reason Code '37': "The claim was processed incorrectly causing an overpayment to be made." Spanish Translation: "La reclamación fue procesada incorrectamente ocasionando un pago en exceso."									HIGLAS
13412.14	The contractor shall apply the provider specific Performance Based Adjustment (PBA) as well as the beneficiary specific HEA to the provider paid amount for DCMP services after the application of the sequestration adjustment (if applicable) **NOTE:** Both the PBA and HEA adjustments can be positive or negative. There will be no HEA adjustments added or subtracted to the provider paid amount for DCMP services between July 1, 2024 to June 30, 2025 for the GUIDE Model.						X			
13412.15	The contractor shall send a new PBA positive/negative amount and HEA positive/negative Amount Indicator and Amount on the HUBC transmission record in the Other Amounts Applied and Indicators field when the PBA and/or HEA adjustment is applied to the provider paid amount. PBA Positive Amount = XW (B5) PBA Negative Amount = XX (B6) HEA Positive Amount = XY (B7) HEA Negative Amount = XZ (B8)						X		X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13412.15.1	The contractors shall modify the HUBCCED program to accept the New Values in the XW (B5), XX (B6), XY (B7), XZ (B8) fields for the GUIDE Payment PBA (Performance Based Adjustment) and HEA (Health Equity Adjustment) to populate the total reimburse amount. **NOTE**: CWF will accept the new HEA "Other Amount Indicator". The HEA adjustment amount will not be added or subtracted to the reimbursement amount."								X	
13412.15.2	The contractor shall modify Consistency Edits 92x5 and 97X1 to accept the new PBA and HEA Indicator Fields and corresponding amount. Consistency Edits 92X5 and 97x1 will accept the positive and negative amounts with the indicators provided in 13412.14.								X	
13412.15.3	The contractors shall update the HCFACLM File (NCH) to accept the new values in the PBA and HEA Indicators filed for the GUIDE payment on the HUBC transmit record.								X	
13412.16	Contractors shall use the following messages for paid GUIDE Model claims, that meet the criteria outlined in BR 13412.3, with one of the CPT/HCPCS codes listed in Appendix A and Appendix B. Contractors shall use the following messages: • CARC: 132 - "Prearranged demonstration project adjustment." • Group Code: CO • MSN Message: 60.4 – "This claim is being processed under a demonstration project." • MSN Spanish Translation: "Esta reclamación está siendo procesada bajo un projecto especial." • MSN Message: 63.10 - "You received this service from a provider who coordinates your care through an organization participating in a CMMI Model. For more information about your care coordination, talk with your doctor		X				X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	or call 1-800-MEDICARE (1-800-633-4227)." • Spanish Language Translation: Recibió este servicio de un proveedor que coordina su cuidado a través de una organización que participa en el Modelo CMMI. Para obtener más información sobre la coordinación de su cuidado, hable con su médico o llame al 1-800-MEDICARE (1-800-633-4227).									
13412.17	Contractors shall deny GUIDE Model claims that meet the criteria outlined in BR 13412.3, but has the CPT/HCPCS code from Appendix C listed. Contractors shall use the following messages: • CARC: 16-“Claim/service lacks information or has submission/billing error(s)” • RARC: M20 - "Missing/incomplete/invalid HCPCS" • Group Code: CO • MSN Message: 60.4 -“This claim is being processed under a demonstration project.” • MSN Spanish Translation: “Esta reclamación está siendo procesada bajo un projecto especial.”		X				X			
13412.18	Contractors shall return as unprocessable claim detail lines that meet the criteria outlined in BR 13412.3, but the GUIDE model CPT/HCPCS code billed is inconsistent with the model tier associated with the beneficiary alignment record. Contractors shall use the following messages: • CARC: 16-“Claim/service lacks information or has submission/billing error(s)” • RARC:N657 "This should be billed with the appropriate code for these services." • Group Code: CO		X				X			
13412.19	For GUIDE Model claims, the contractor shall only process detail lines that meet the criteria outlined in		X				X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	BR 13412.3.									
13412.20	Contractors shall return as unprocessable claims that include at least one claim detail that meet the criteria for the GUIDE demonstration but other detail lines that do not. Contractors shall use the following messages: • CARC: 16-"Claim/service lacks information or has submission/billing error(s)" • RARC: N61-"Rebill services on separate claims." • Group Code: CO		X				X			
13412.21	Contractors shall return as unprocessable claim details where a new GUIDE model DCMP or respite care procedure is billed but the rendering provider is not aligned for the dates of service. Contractors shall use the following messages: • CARC: 185 - "The rendering provider is not eligible to perform the service billed." • RARC: N95 -"This provider type/provider specialty may not bill this service." • Group Code: CO		X				X			
13412.21.1	Contractors shall return as unprocessable claim details where a new GUIDE model DCMP or respite care procedure is billed but the beneficiary is not aligned for the dates of service. Contractors shall use the following messages: • CARC: 96-" Non-covered charge(s)." • RARC: M138-" Patient identified as a demonstration participant but the patient was not enrolled in the demonstration at the time services were rendered. Coverage is limited to demonstration participants." • Group Code: CO		X				X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13412.22	Contractors shall deny claim details for DCMP services if none of the diagnosis codes on the claim has a dementia diagnosis code (refer to Attachment D). Contractors shall use the following messages for the claim denial. • CARC: 11- "The diagnosis is inconsistent with the procedure." • RARC: M76-"Missing/incomplete/invalid diagnosis or condition." • Group Code: CO • MSN Message: 14.9 -"Medicare cannot pay for this service for the diagnosis shown on the claim." • MSN Spanish Translation: "Medicare no puede pagar por este servicio debido al diagnìstico indicado en la reclamacín."		X				X			
13412.23	Contractors shall deny claim details for DCMP services where more than one DCMP service is billed for a given beneficiary during a calendar month. Contractors shall use the following messages for the claim denial. • CARC: 119-"Benefit maximum for this time period or occurrence has been reached." • RARC: N640-"Exceeds number/frequency approved/allowed with time period." • Group Code: CO • MSN Message: 20.5-"These services cannot be paid because your benefits are exhausted at this time." • MSN Spanish Translation: "Estos servicios no pueden ser pagados porque sus beneficios se han agotado."		X				X			
13412.24	Contractors shall deny GUIDE Model respite care service detail lines, which meet the criteria outlined in BR 13412.3, when there is no beneficiary respite eligibility indicator on the beneficiary alignment file.		X				X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• CARC: 96 - "Non-covered charge(s).” • RARC: N30 - "Patient ineligible for this service." • Group Code: CO • MSN Message: 60.4 -“This claim is being processed under a demonstration project.” • MSN Spanish Translation: “Esta reclamación está siendo procesada bajo un projecto especial.”									
13412.25	CMS shall send a test file to the contractors to validate the file layout, on or about June 5, 2024.						X		X	CMS
13412.26	CMS shall facilitate up to 2 one-hour kick-off calls prior to the start of UAT during the week of May 13, 2024. These calls will be used if needed to discuss any testing questions/concerns.		X				X		X	CMS
13412.26.1	Contractors shall submit to CMS the list of attendee’s email addresses to be invited to the kick-off calls in BR 13412.26 and all other UAT calls in BR 13412.27, by May 10, 2024. Contact for emails: charlotte.kaye1@cms.hhs.gov		X				X		X	CMS
13412.27	CMS shall facilitate 1-hour weekly calls during UAT testing, beginning the week of June 3, 2024.		X				X		X	CMS, HIGLAS
13412.28	CMS shall send a test file to the contractors to validate the file layout, on or about March 18, 2024.									CMS
13412.29	Contractors shall add a new benefit enhancement indicator for the GUIDE Model: • "O" - GUIDE Model Beneficiary covering all services								X	IDR, NCH
13412.30	Effective with beneficiary alignment files processed on or after the implementation of the CR, contractors shall trigger an Informational Unsolicited Response (IUR) Edit ‘7125’ that apply to Part B claims for the following benefit enhancement indicator when the following criteria are met for beneficiary changes								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	(Demo Code A6): • Demo Code A6 BEs Indicator - “O” **NOTE**: The quarterly full replacement file will also serve as the reprocessing file. The IUR generates when there is a change in the beneficiary’s alignment date.									
13412.31	The contractor shall not generate IUR '7125' for claims that process within 90 days after the beneficiary termination date on the Beneficiary Alignment files.								X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13412.32	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the “MLN Connects” listserv to get MLN content notifications. You don’t need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.		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

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: 4

Appendix A GUIDE DCMP G-Code Descriptions

G-Code	Amount	G-Code Description	**Model Tier**	Eligible for Respite Care
G-Code 1	$150	Management of new patient-caregiver dyad with dementia, low complexity, for use in CMMI Model	**Tier 1**	No
G-Code 2	$275	Management of new patient-caregiver dyad with dementia, moderate complexity, for use in CMMI Model	**Tier 2**	Yes
G-Code 3	$360	Management of new patient-caregiver dyad with dementia, high complexity, for use in CMMI Model	**Tier 3**	Yes
G-Code 4	$230	Management of a new patient with dementia, low complexity, for use in CMMI Model	**Tier 4**	No
G-Code 5	$390	Management of a new patient with dementia, moderate/severe complexity, for use in CMMI Model	**Tier 5**	No
G-Code 6	$65	Management of established patient-caregiver dyad with dementia, low complexity, for use in CMMI Model	**Tier 6**	No
G-Code 7	$120	Management of established patient-caregiver dyad with dementia, moderate complexity, for use in CMMI Model	**Tier 7**	Yes
G-Code 8	$220	Management of established patient-caregiver dyad with dementia, high complexity, for use in CMMI Model	**Tier 8**	Yes
G-Code 9	$120	Management of established patient with cognitive impairment with dementia, low complexity, for use in CMMI Model	**Tier 9**	No
G-Code 10	$215	Management of established patient with cognitive impairment, moderate/high complexity, for use in CMMI Model	**Tier 10**	No

Appendix B Respite Services G-Codes

G-Code 11	In-home respite care, 4-hour unit, for use in CMMI Model	$104
G-Code 12	Adult day center, 8-hour unit, for use in CMMI Model	$78
G-Code 13	Facility-based respite, 24-hour unit, for use in CMMI Model	$260

Appendix C: GUIDE Excluded Codes

Service Description	HCPCS Codes
Advance care planning	99497, 99498
Annual Wellness Visits	G0438, G0439
Cognitive Assessment and Planning	99483
Technology-based check-in services	G2012, G2252
Transitional Care Management	99495-99496
Chronic Care Management	99487, 99489-99491, 99437, 99439, G0506
Principal Care Management	99424–99427
Care Plan Oversight	G0181-G0182
Administration of patient-focused health risk assessment (HRA)	96160
Administration of caregiver-focused HRA	96161
Depression screening	G0444
Caregiver Skills Training • Group Caregiver Behavior Management/ Modification Training Services	96202 and 96203
Caregiver Skills Training • Caregiver Training Services under a Therapy Plan of Care established by a PT, OT, SLP	9X015, 9X016, 9X017
Community Health Integration Services • Referral and coordination of community-based services and supports; assessment and planning to address social determinants of health (SDOH)	GXXX1 and GXXX2

<table>
<tr><td>Principal Illness Navigation Services
Comprehensive assessment; developing a disease-specific care plan; ongoing monitoring and support; medication reconciliation and management; care coordination and transitional care management; referral and coordination of services and supports</td><td>GXXX3 and GXXX4</td></tr>
<tr><td>Comprehensive assessment that includes an SDOH domain
Administration of a Standardized, Evidence-based Social Determinants of Health Risk Assessment</td><td>GXXX5</td></tr>
</table>

Appendix D: Dementia Diagnostic Codes

ICD-10 Dementia Codes	ICD-10 Dementia Code Meaning
F01.50	Vascular dementia
F01.511	Vascular dementia, unspecified severity, with agitation
F01.518	Vascular dementia, unspecified severity, with other behavioral disturbance
F02.80	Dementia in other diseases classified elsewhere
F02.811	Dementia in other diseases classified elsewhere, unspecified severity, with agitation
F02.818	Dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance
F03.90	Dementia (degenerative (primary)) (old age) (persisting)
F03.911	Unspecified dementia, unspecified severity, with agitation
F03.918	Unspecified dementia, unspecified severity, with other behavioral disturbance
G30.0	Alzheimer's disease
G30.1	Alzheimer's disease with late onset
G30.8	Other Alzheimer's disease
G30.9	Alzheimer's disease, unspecified
G31.1	Senile degeneration of brain, not elsewhere classified
G31.2	Degeneration of nervous system due to alcohol
G31.01	Pick's disease
G31.09	Other front temporal dementia
G31.83	Neurocognitive disorder with Lewy bodies