

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-19 Demonstrations	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12647	Date: May 17, 2024
	Change Request 13412

Transmittal 12563 issued April 1, 2024, is being rescinded and replaced by Transmittal 12647, dated May 17, 2024, to revise the background and policy sections updating the cadence of the CSRS files from monthly to bi-weekly as well as Business Requirements (BRs) 13412.7.1.1 and 13412.30 and CMS specialty/operations contractor shall deliver the provider participant and beneficiary alignment production files on or about July 19, 2024. This correction revises BRs 13412.2.1, 13412.6.1 and 13412.7. All other information remains the same.

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: 12647	Date: May 17, 2024	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 bi-weekly.

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. Rates for the model tiers are based on whether the beneficiary is part of a patient-caregiver dyad; the severity/complexity of the dementia; and whether the beneficiary is within its first 6-months of participating in the model, or if the beneficiary has been in the model for more than a 6-month span.

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 amount will be zero but the provider should have a billed amount. 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. To account for geographic variation in costs, the DCMP and respite base rates will be adjusted by the Medicare Geographic Adjustment Factor (GAF) for each DCMP and respite claim submitted by a GUIDE Participant. 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. Appendix E is the file layout for the Geographic Adjustment Factor (GAF) that will be made to the DCMP and respite code. The DCMP and respite payments are adjusted for geographic area wage differences using the geographic adjustment factor (GAF). GAFs are a weighted composite of each Physician Fee Schedule (PFS) localities work, practice expense (PE) and malpractice (MP) expense geographic practice cost indices (GPCIs). Any updates to Appendices A, B, C, and D will be provided through a CR.

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 two weeks. Beneficiary 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.

The GUIDE payments will not include non-physician practitioner's payment reduction. 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			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		
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	CVM
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:							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	
	<ul style="list-style-type: none"> 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 Billing TIN/rendering 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. If codes from Appendix A are billed the beneficiary tier must match the procedure code. If codes from Appendix B are billed the beneficiary must have a respite eligibility indicator. 									
13412.3.1	The contractors shall ensure that only participating providers accepting assignment will be included in the GUIDE Model.						X			
13412.3.2	CMS shall provide an update for Appendix A, B, C, D, and E of the GUIDE Model on a quarterly basis.								CMS	
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						X		X	

Number	Requirement	Responsibility										
		A/B MAC			D M E	Shared- System Maintainers				Other		
		A	B	H H H		F I S S	M C S	V M S	C W F			
	be '0'.											
13412.5.1	<p>Contractors shall use the following messages for GUIDE Model “no pay” respite services.</p> <ul style="list-style-type: none"> • 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 proyectoproyecto especial.” 		X				X					
13412.5.2	<p>Contractors shall create a new monthly report for ‘no pay’ respite care services and include the following information:</p> <ul style="list-style-type: none"> • Billing Provider Transaction Access Number (PTAN) • Billing Provider NPI • Rendering Provider PTAN • Rendering Provider NPI • 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 						X					

Number	Requirement	Responsibility								
		A/B MAC			D M E	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
	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. CMS issued a TDL with further instruction on sending the test data. 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. 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. CMS specialty/operations contractor shall deliver the initial provider participant and beneficiary alignment files on or about June 3, 2024, for UAT testing.		X						CMS	
13412.6.2	The contractors shall accept the file layouts to support the GUIDE Model processing changes.					X		X		
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: <ul style="list-style-type: none"> Beneficiary Model Tier (2 characters) HEA Amount (3 characters) Respite Eligibility Indicator (1 character) <p>Note: Character string should be 6 characters</p>					X		X		

Number	Requirement	Responsibility								Other
		A/B MAC			D M E M A C	Shared- System Maintainers				
		A	B	H H H		F I S S	M C S	V M S	C W F	
13412.9	<p>Contractors shall perform limited validation to ensure the file is well formed. The validation checks shall include:</p> <ul style="list-style-type: none"> 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	<p>The contractor shall add GUIDE Model beneficiary data to the ACOB Auxiliary File viewable within the HIMR with the following data elements included:</p> <ul style="list-style-type: none"> 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 Model Tier HEA Amount Respite Eligibility Indicator <p>NOTE: The value indicating a GUIDE Beneficiary on the ACOB Auxiliary file is G = GUIDE.</p>								X	
13412.11	The contractor shall modify the beneficiary alignment output file with the most current HICN to be provided to the Virtual Data Centers (VDCs) for the Multi-Carrier System (MCS) to receive.						X		X	VDC
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	

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	
	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) percentage as well as the beneficiary specific HEA dollar amount 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. Any PBA adjustment will be determined first followed by any HEA adjustment. There will be no HEA adjustments added or subtracted to the provider paid amount for DCMP service sent July 1, 2024 through June 30, 2025 for the GUIDE Model.						X			
13412.15	The contractor shall send a new PBA/HEA positive/negative amount (Other Amount field) and new Other Amount Indicator value (Other Amount Indicator field) on the HUBC transmission record. PBA Positive Amount = B5 PBA Negative Amount = B6 HEA Positive Amount = B7						X		X	IDR

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		
	HEA Negative Amount = B8										
13412.15.1	The contractors shall modify the HUBCCED program to accept the new values in the B5, B6, B7, B8 in the “Other Amount Indicator” field for the GUIDE Payment PBA (Performance Based Adjustment) and HEA (Health Equity Adjustment). NOTE: The HEA adjustment amount will not be added to or subtracted from the reimbursement amount.										X
13412.15.2	The contractor shall modify Consistency Edit 92X5 and 97X1 to validate the new PBA/HEA positive/negative values and corresponding amounts. NOTE: 97X1 will validate the new indicators and 92X5 will validate the Provider Reimbursement Amount.										X
13412.15.3	The contractors shall update the HCFACLM File (NCH) to accept the new values for the PBA and HEA values (Other Amount Indicator field) for the GUIDE payment on the HUBC transmit record.										X NCH
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: <ul style="list-style-type: none"> 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 proyecto 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 		X					X			

Number	Requirement	Responsibility								Other
		A/B MAC			D M E M A C	Shared- System Maintainers				
		A	B	H H H		F I S S	M C S	V M S	C W F	
	<p>your care coordination, talk with your doctor or call 1-800-MEDICARE (1-800-633-4227)."</p> <ul style="list-style-type: none"> 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	<p>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:</p> <ul style="list-style-type: none"> 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 proyecto especial.” 		X				X			
13412.18	<p>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:</p> <ul style="list-style-type: none"> 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			

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		
13412.19	For GUIDE Model claims, the contractor shall only process detail lines that meet the criteria outlined in BR 13412.3.		X				X				
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: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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			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		
13412.22	<p>Contractors shall deny claim details for DCMP and respite care services if none of the diagnosis codes on the claim has a dementia diagnosis code (refer to Appendix D). Contractors shall use the following messages for the claim denial.</p> <ul style="list-style-type: none"> • 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 diagnóstico indicado en la reclamación.” 		X				X				
13412.23	<p>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.</p> <ul style="list-style-type: none"> • 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		X				X				

Number	Requirement	Responsibility								Other
		A/B MAC			D M E M A C	Shared- System Maintainers				
		A	B	H H H		F I S S	M C S	V M S	C W F	
	<p>following criteria are met for beneficiary changes (Demo Code A6):</p> <ul style="list-style-type: none"> • Demo Code A6 BEs Indicator - “O” <p>NOTE: The bi-weekly full replacement file will also serve as the reprocessing file. The IUR generates when there is a change in the beneficiary’s alignment date.</p> <p>NOTE: Contractor shall generate IUR 7125 for claims in Part B history that meet GUIDE Model criteria (13412.3 and 13412.13).</p>									
13412.30.1	The contractor shall provide the provider participant file for CWF to use in the processing of the IURs.						X		X	
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	
13412.32	Contractors shall exclude all Medicare Secondary Payer (MSP) claims from the GUIDE Model.		X				X		X	
13412.33	Contractors shall waive the non-physician practitioner’s payment reduction for those non-physicians billing the GUIDE DCMP and Respite Services.		X							
13412.34	<p>Contractors shall make the necessary system changes to retrieve the Part B GUIDE payment file from the CMS mainframe and load it into their systems prior to July 1, 2024.</p> <p>Note: The Part B GUIDE Fee Schedule file layout is attached as Appendix E.</p>						X			
13412.35	To facilitate systems testing, contractors/data centers shall retrieve a preliminary test file from the CMS mainframe telecommunication systems on or about April 1, 2024.						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	
	Response Code Details: Detail Record ID Error - The data in the file does not conform to the file layout specified for the file transfer. The data format of the field or the data in the field does not conform to the list of valid values specified.									

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		
13412.41	Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.		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): Charlotte Kaye, 9178176965 or charlotte.kaye1@cms.hhs.gov , Sage Hart, sage.hart@cms.hhs.gov , Justine Kinney, (667) 414-04 or justine.kinney@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 GUIDE Dementia Care Model Payment (DCMP) G-Code Descriptions

G-Code	G-Code Description	Model Tier	Eligible for Respite Care
G0519	Management of new patient-caregiver dyad with dementia, low complexity, for use in CMMI Model	Tier 1	No
G0520	Management of new patient-caregiver dyad with dementia, moderate complexity, for use in CMMI Model	Tier 2	Yes
G0521	Management of new patient-caregiver dyad with dementia, high complexity, for use in CMMI Model	Tier 3	Yes
G0522	Management of a new patient with dementia, low complexity, for use in CMMI Model	Tier 4	No
G0523	Management of a new patient with dementia, moderate/severe complexity, for use in CMMI Model	Tier 5	No
G0524	Management of established patient-caregiver dyad with dementia, low complexity, for use in CMMI Model	Tier 6	No
G0525	Management of established patient-caregiver dyad with dementia, moderate complexity, for use in CMMI Model	Tier 7	Yes
G0526	Management of established patient-caregiver dyad with dementia, high complexity, for use in CMMI Model	Tier 8	Yes
G0527	Management of established patient with cognitive impairment with dementia, low complexity, for use in CMMI Model	Tier 9	No
G0528	Management of established patient with cognitive impairment, moderate/high complexity, for use in CMMI Model	Tier 10	No

Appendix B Respite Services G-Codes

G0529	In-home respite care, 4-hour unit, for use in CMMI Model
G0530	Adult day center, 8-hour unit, for use in CMMI Model
G0531	Facility-based respite, 24-hour unit, for use in CMMI Model

Appendix C: GUIDE Excluded Codes

Service Type HCPCS Codes	Service Type HCPCS Codes
Advance care planning	99497, 99498
Welcome to Medicare and Annual Wellness Visits	G0402, G0438, G0439
Home Health Care Plan Oversight	G0181
Hospice Care Plan Oversight	G0182
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
Administration of patient-focused health risk assessment (HRA)	96160
Administration of caregiver-focused HRA	96161
Depression screening	G0444
Group Caregiver Behavior Management/ Modification Training Services	96202, 96203
Caregiver Training Services under a Therapy Plan of Care established by a PT, OT, SLP	97550, 97551, and 97552
Community Health Integration Services	G0019, G0022
Principal Illness Navigation Services	G0023, G0024, G0140, and G0146
Administration of a Standardized, Evidence-based Social Determinants of Health Risk Assessment	G0136

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
F01.A0	Vascular dementia, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F01.A11	Vascular dementia, mild, with agitation
F01.A18	Vascular dementia, mild, with other behavioral disturbance
F01.A2	Vascular dementia, mild, with psychotic disturbance
F01.A3	Vascular dementia, mild, with mood disturbance
F01.A4	Vascular dementia, mild, with anxiety
F01.B0	Vascular dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F01.B11	Vascular dementia, moderate, with agitation
F01.B18	Vascular dementia, moderate, with other behavioral disturbance
F01.B2	Vascular dementia, moderate, with psychotic disturbance
F01.B3	Vascular dementia, moderate, with mood disturbance
F01.B4	Vascular dementia, moderate, with anxiety
F01.C0	Vascular dementia, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F01.C11	Vascular dementia, severe, with agitation
F01.C18	Vascular dementia, severe, with other behavioral disturbance
F01.C2	Vascular dementia, severe, with psychotic disturbance
F01.C3	Vascular dementia, severe, with mood disturbance
ICD-10 Dementia Codes	ICD-10 Dementia Code Meaning
F01.C4	Vascular dementia, severe, with anxiety
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
F02.A0	Dementia in other diseases classified elsewhere, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F02.A11	Dementia in other diseases classified elsewhere, mild, with agitation
F02.A18	Dementia in other diseases classified elsewhere, mild, with other behavioral disturbance
F02.A2	Dementia in other diseases classified elsewhere, mild, with psychotic disturbance
F02.A3	Dementia in other diseases classified elsewhere, mild, with mood disturbance
F02.A4	Dementia in other diseases classified elsewhere, mild, with anxiety
F02.B0	Dementia in other diseases classified elsewhere, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F02.B11	Dementia in other diseases classified elsewhere, moderate, with agitation
F02.B18	Dementia in other diseases classified elsewhere, moderate, with other behavioral disturbance
F02.B2	Dementia in other diseases classified elsewhere, moderate, with psychotic disturbance
F02.B3	Dementia in other diseases classified elsewhere, moderate, with mood disturbance
F02.B4	Dementia in other diseases classified elsewhere, moderate, with anxiety
ICD-10 Dementia Codes	ICD-10 Dementia Code Meaning
F02.C0	Dementia in other diseases classified elsewhere, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F02.C11	Dementia in other diseases classified elsewhere, severe, with agitation
F02.C18	Dementia in other diseases classified elsewhere, severe, with other behavioral disturbance
F02.C2	Dementia in other diseases classified elsewhere, severe, with psychotic disturbance
F02.C3	Dementia in other diseases classified elsewhere, severe, with mood disturbance
F02.C4	Dementia in other diseases classified elsewhere, severe, with anxiety
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
F03.A0	Unspecified dementia, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F03.A11	Unspecified dementia, mild, with agitation

F03.A18	Unspecified dementia, mild, with other behavioral disturbance
F03.A2	Unspecified dementia, mild, with psychotic disturbance
F03.A3	Unspecified dementia, mild, with mood disturbance
F03.A4	Unspecified dementia, mild, with anxiety
F03.B0	Unspecified dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F03.B11	Unspecified dementia, moderate, with agitation
F03.B18	Unspecified dementia, moderate, with other behavioral disturbance
F03.B2	Unspecified dementia, moderate, with psychotic disturbance
F03.B3	Unspecified dementia, moderate, with mood disturbance
ICD-10 Dementia Codes	ICD-10 Dementia Code Meaning
F03.B4	Unspecified dementia, moderate, with anxiety
F03.C0	Unspecified dementia, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F03.C11	Unspecified dementia, severe, with agitation
F03.C18	Unspecified dementia, severe, with other behavioral disturbance
F03.C2	Unspecified dementia, severe, with psychotic disturbance
F03.C3	Unspecified dementia, severe, with mood disturbance
F03.C4	Unspecified dementia, severe, with anxiety
F10.27	Alcohol dependence with alcohol-induced persisting dementia
F10.97	Alcohol use, unspecified with alcohol-induced persisting dementia
F13.27	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting dementia
F13.97	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced persisting dementia
F18.97	Inhalant use, unspecified with inhalant-induced persisting dementia
F19.17	Other psychoactive substance abuse with psychoactive substance-induced persisting dementia
F19.27	Other psychoactive substance dependence with psychoactive substance-induced persisting dementia
F19.97	Other psychoactive substance use, unspecified with psychoactive substance-induced persisting dementia
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
G31.01	Pick's disease
G31.09	Other front temporal dementia
ICD-10 Dementia Codes	ICD-10 Dementia Code Meaning
G31.1	Senile degeneration of brain, not elsewhere classified
G31.2	Degeneration of nervous system due to alcohol
G31.83	Neurocognitive disorder with Lewy bodies

Appendix E: GUIDE Model file layout for the Geographic Adjustment Factor (GAF)

FIELD #	ITEM	LOCATION	LENGTH & PIC
1	A/B MAC Contractor ID #	1-5	5 Pic x(5)
2	Locality	6-7	2 Pic x(2)
3	HCPCS Code	8-12	5 Pic x(5)
4	Modifier	13-14	2 Pic x(2)
5	Geographically Adjusted Fee	15-23	9 Pic 9(7)v99
6	Payment Effective Date (CCYYMMDD)	24-31	8 Pic x(8)
7	Filler	32-51	20 Pic x(20)