

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Medicare & Medicaid Services



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Implementation Date: April 4, 2016

## Comprehensive Care for Joint Replacement Model (CJR) Provider Education

### Provider Types Affected

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This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for Comprehensive CJR services provided to Medicare beneficiaries.

### What You Need to Know

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Change Request (CR) 9533 supplies information to providers about the CJR model. The intent of the CJR model is to promote quality and financial accountability for episodes of care surrounding a Lower-Extremity Joint Replacement (LEJR) or reattachment of a lower extremity procedure. CJR will test whether bundled payments to certain acute care hospitals for LEJR episodes of care will reduce Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries. Make sure that your billing staffs are aware of these changes.

### Background

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Section 1115A of the Social Security Act (the Act) authorizes the Centers for Medicare & Medicaid Services (CMS) to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to Medicare, Medicaid, and Children's Health Insurance Program beneficiaries. Under this authority, CMS published a rule to implement a new five year payment model called the Comprehensive Care for Joint Replacement (CJR) model on April 1, 2016.

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Under the CJR model, acute care hospitals in certain selected geographic areas will take on quality and payment accountability for retrospectively calculated bundled payments for LEJR episodes. Episodes will begin with admission to an acute care hospital for an LEJR procedure that is paid under the Inpatient Prospective Payment System (IPPS) through Medical Severity Diagnosis-Related Group (MS-DRG) 469 (Major joint replacement or reattachment of lower extremity with MCC) or 470 (Major joint replacement or reattachment of lower extremity without MCC) and end 90 days after the date of discharge from the hospital.

## Key Points of CR9533

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### **CJR Episodes of Care**

LEJR procedures are currently paid under the IPPS through: MS-DRG 469 or MS-DRG 470. The episode will include the LEJR procedure, inpatient stay, and all related care covered under Medicare Parts A and B within the 90 days after discharge. The day of discharge is counted as the first day of the 90-day bundle.

### **CJR Participant Hospitals**

The model requires all hospitals paid under the IPPS in selected geographic areas to participate in the CJR model, with limited exceptions. A list of the selected geographic areas and participant hospitals is available at <https://innovation.cms.gov/initiatives/cjr> on the Internet. Participant hospitals initiate episodes when an LEJR procedure is performed within the hospital and will be at financial risk for the cost of the services included in the bundle. Eligible beneficiaries who elect to receive care at these hospitals will automatically be included in the model.

### **CJR Model Beneficiary Inclusion Criteria**

Medicare beneficiaries whose care will be included in the CJR model must meet the following criteria upon admission to the anchor hospitalization:

- The beneficiary is enrolled in Medicare Part A and Part B;
- The beneficiary's eligibility for Medicare is not on the basis of the End-Stage Renal Disease benefit;
- The beneficiary is not enrolled in any managed care plan;
- The beneficiary is not covered under a United Mine Workers of America health plan; and
- Medicare is the primary payer.

If at any time during the episode the beneficiary no longer meets all of these criteria, the episode is canceled.

### **CJR Performance Years**

CMS will implement the CJR model for 5 performance years, as detailed in the table below. Performance years for the model correlate to calendar years with the exception of performance year 1, which is April 1, 2016, through December 31, 2016.

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**CJR Model: 5 Performance Years**

Performance Year	Date for Episodes
Performance Year 1 (calendar year 2016)	Episodes that start on or after April 1, 2016, and end on or before December 31, 2016
Performance Year 2 (calendar year 2017)	Episodes that end between January 1, 2017, and December 31, 2017, inclusive
Performance Year 3 (calendar year 2018):	Episodes that end between January 1, 2018, and December 31, 2018, inclusive
Performance Year 4 (calendar year 2019):	Episodes that end between January 1, 2019, and December 31, 2019, inclusive
Performance Year 5 (calendar year 2020):	Episodes that end between January 1, 2020, and December 31, 2020, inclusive

**CJR Episode Reconciliation Activities**

CMS will continue paying hospitals and other providers and suppliers according to the usual Medicare fee-for-service payment systems during all performance years. After completion of a performance year, Medicare will compare or “reconcile” actual claims paid for a beneficiary during the 90 day episode to an established target price. The target price is an expected amount for the total cost of care of the episode. Hospitals will receive separate target prices to reflect expected spending for episodes assigned to MS-DRGs 469 and 470, as well as hip fracture status. If the actual spending is lower than the target price, the difference will be paid to the hospital, subject to certain adjustments, such as for quality. This payment will be called a reconciliation payment. If actual spending is higher than the target price, hospitals will be responsible for repayment of the difference to Medicare, subject to certain adjustments, such as for quality.

**Identifying CJR Claims**

To validate the retroactive identification of CJR episodes, CMS is associating the Demonstration Code 75 with the CJR initiative. This code will also be utilized in future CRs to operationalize a waiver of the three-day stay requirement for covered Skilled Nursing Facility (SNF) services, effective for CJR episodes beginning on or after January 1, 2017.

Medicare will automatically apply the CJR demonstration code to claims meeting the criteria for inclusion in the demonstration. **Participant hospitals need not include demonstration code 75 on their claims.** Instructions for submission of claims for SNF services rendered to beneficiaries in a CJR episode of care will be communicated once the waiver of the three-day stay requirement is operationalized.

**Waivers and Amendments of Medicare Program Rules**

The CJR model waives certain existing payment system requirements to provide additional flexibilities to hospitals participating in CJR, as well as other providers that furnish services to beneficiaries in CJR episodes. The purpose of such flexibilities would be to increase LEJR episode quality and decrease episode spending or provider and supplier internal costs,

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or both, and to provide better, more coordinated care for beneficiaries and improved financial efficiencies for Medicare, providers, and beneficiaries.

### *Post-Discharge Home Visits*

In order for Medicare to pay for home health services, a beneficiary must be determined to be "home bound." A beneficiary is considered to be confined to the home if the beneficiary has a condition, due to an illness or injury, that restricts his or her ability to leave home except with the assistance of another individual or the aid of a supportive device (that is, crutches, a cane, a wheelchair or a walker) or if the beneficiary has a condition such that leaving his or her home is medically contraindicated. Additional information regarding the homebound requirement is available in the "Medicare Benefit Policy Manual;" [Chapter 7](#), Home Health Services, Section 30.1.1, Patient Confined to the Home.

Medicare policy allows physicians and Non-Physician Practitioners (NPPs) to furnish and bill for visits to any beneficiary's home or place of residence under the Medicare Physician Fee Schedule (MPFS). Medicare policy also allows such physicians and practitioners to bill Medicare for services furnished incident to their services by licensed clinical staff. Additional information regarding the "incident to" requirements is available in [42 CFR 410.26](#).

For those CJR beneficiaries who could benefit from home visits by licensed clinical staff for purposes of assessment and monitoring of their clinical condition, care coordination, and improving adherence with treatment, CMS will waive the "incident to" direct physician supervision requirement to allow a beneficiary who does not qualify for Medicare home health services to receive post-discharge visits in his or her home or place of residence any time during the episode, subject to the following conditions:

- Licensed clinical staff will provide the service under the general supervision of a physician or NPP. These staff can come from a private physician office or may be either an employee or a contractor of the participant hospital.
- Services will be billed under the MPFS by the supervising physician or NPP or by the hospital or other party to which the supervising physician has reassigned his or her billing rights.
- Up to 9 post discharge home visits can be billed and paid per beneficiary during each CJR episode, defined as the 90-day period following the anchor hospitalization.
- The service cannot be furnished to a CJR beneficiary who has qualified, or would qualify, for home health services when the visit was furnished.
- All other Medicare rules for coverage and payment of services incident to a physician's service continue to apply.

As described in the "Medicare Claims Processing Manual", [Chapter 12](#), Sections 40-40.4, Medicare policy generally does not allow for separate billing and payment for a postoperative visit furnished during the global period of a surgery when it is related to recovery from the surgery. However, for CJR, CMS will allow the surgeon or other practitioners to bill and be paid separately for a post-discharge home visit that was furnished

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in accordance with these conditions. All other Medicare rules for global surgery billing during the 90 day post-operative period continue to apply.

CMS expects that the post-discharge home visits by licensed clinical staff could include patient assessment, monitoring, assessment of functional status and fall risk, review of medications, assessment of adherence with treatment recommendations, patient education, communication and coordination with other treating clinicians, and care management to improve beneficiary connections to community and other services.

The service will be billed under the MPFS with a HCPCS G-code (G9490) specific to the CJR post-discharge home visit, as listed in Attachment A. The post-discharge home visit HCPCS code will be payable for CJR model beneficiaries beginning April 1, 2016, the start date of the first CJR model performance year. Claims submitted for post-discharge home visits for the CJR model will be accepted only when the claim contains the CJR specific HCPCS G-Code. Although CMS is associating the Demonstration Code 75 with the CJR initiative, no demonstration code is needed or required on Part B claims submitted with the post-discharge home visit HCPCS G-Code.

Additional information on billing and payment for the post-discharge home visit HCPCS G-Code will be available in the April 2016 release of the MPFS Recurring Update. Future updates to the relative value units (RVUs) and payment for this HCPCS code will be included in the MPFS final rules and recurring updates each year.

### *Billing and Payment for Telehealth Services*

Medicare policy covers and pays for telehealth services when beneficiaries are located in specific geographic areas. Within those geographic areas, beneficiaries must be located in one of the health care settings that are specified in the statute as eligible originating sites. The service must be on the list of approved Medicare telehealth services. Medicare pays a facility fee to the originating site and provides separate payment to the distant site practitioner for the service. Additional information regarding Medicare telehealth services is available in the “Medicare Benefit Policy Manual,” [Chapter 15](#), Section 270 and the “Medicare Claims Processing Manual,” [Chapter 12](#), Section 190.

Under CJR, CMS will allow a beneficiary in a CJR episode in any geographic area to receive services via telehealth. CMS also will allow a home or place of residence to be an originating site for beneficiaries in a CJR episode. This will allow payment of claims for telehealth services delivered to beneficiaries at eligible originating sites or at their residence, regardless of the geographic location of the beneficiary. CMS will waive these telehealth requirements, subject to the following conditions:

- Telehealth services cannot substitute for in-person home health visits for patients under a home health episode of care.
- Telehealth services performed by social workers for patients under a home health episode of care will not be covered under the CJR model.
- The telehealth geographic area waiver and the allowance of home as an originating site under the CJR model does not apply for instances where a physician or allowed

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NPP is performing a face-to-face encounter for the purposes of certifying patient eligibility for the Medicare home health benefit.

- The principal diagnosis code reported on the telehealth claim cannot be one that is specifically excluded from the CJR episode definition.
- If the beneficiary is at home, the physician cannot furnish any telehealth service with a descriptor that precludes delivering the service in the home (for example, a hospital visit code).
- If the physician is furnishing an evaluation and management visit via telehealth to a beneficiary at home, the visit must be billed by one of nine unique HCPCS G-codes developed for the CJR model that reflect the home setting.
- For CJR telehealth home visits billed with HCPCS codes G9484, G9485, G9488, and G9489, the physician must document in the medical record that auxiliary licensed clinical staff were available on site in the patient's home during the visit or document the reason that such a high-level visit would not require such personnel.
- Physicians billing distant site telehealth services under these waivers must include the GT modifier on the claim, which attests that the service was furnished in accordance with all relevant coverage and payment requirements.
- The facility fee paid by Medicare to an originating site for a telehealth service will be waived if the service was originated in the beneficiary's home.

The telehealth home visits will be billed under the MPFS with one of nine HCPCS G-code specific to the CJR telehealth home visits. Those codes are G9481, G9482, G9483, G9484, G9485, G9586, G9487, G9488, and G9499. Attachment A of CR9533 provides the long descriptors of these codes. The telehealth home visit HCPCS codes will be payable for CJR model beneficiaries beginning April 1, 2016, the start date of the first CJR model performance year. Claims submitted for telehealth home visits for the CJR model will be accepted only when the claim contains one of nine of the CJR specific HCPCS G-Code. **Although CMS is associating the Demonstration Code 75 with the CJR initiative, no demonstration code is needed or required on Part B claims submitted with the post-discharge home visit HCPCS G-Code.** Additional information on billing and payment for the telehealth home visit HCPCS G-Codes will be available in the April 2016 release of the MPFS Recurring Update. Future updates to the RVUs and payment for these HCPCS codes will be included in the MPFS final rules and recurring updates each year.

## Additional Information

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The official instruction, CR9533, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R140DEMO.pdf> on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - How Does It Work.

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