510.200 Time periods, included and excluded services, and attribution.

(a) Time periods. All episodes must begin on or after April 1, 2016 and end on or before September 30, 2021.

(b) Included services. All Medicare Parts A and B items and services are included in the episode, except as specified in paragraph (d) of this section. These services include, but are not limited to, the following:

(1) Physicians' services.

(2) Inpatient hospital services (including hospital readmissions).

(3) IPF services.

(4) LTCH services.

(5) IRF services.

(6) SNF services.

(7) HHA services.

(8) Hospital outpatient services.

(9) Outpatient therapy services.

(10) Clinical laboratory services.

(11) DME.

(12) Part B drugs and biologicals.

(13) Hospice services.

(14) PBPM payments under models tested under section 1115A of the Act.

(c) Episode attribution. All items and services included in the episode are attributed to the participant hospital at which the anchor hospitalization occurs.

(d) Excluded services. The following items, services, and payments are excluded from the episode:

(1) Hemophilia clotting factors provided in accordance with § 412.115 of this chapter.

(2) New technology add-on payments, as defined in part 412, subpart F of this chapter.

(3) Transitional pass-through payments for medical devices as defined in § 419.66 of this chapter.

(4) Items and services unrelated to the anchor hospitalization, as determined by CMS. Excluded services include, but are not limited to, the following:

(i) Inpatient hospital admissions for MS-DRGs that group to the following categories of diagnoses:

(A) Oncology.

(B) Trauma medical.

(C) Chronic disease surgical, such as prostatectomy.

(D) Acute disease surgical, such as appendectomy.

(ii) Medicare Part B services, as identified by the principal ICD-CM diagnosis code on the claim (based on the ICD-CM version in use during the performance year) that group to the following categories of diagnoses:

(A) Acute disease diagnoses, such as severe head injury.

(B) Certain chronic disease diagnoses, as specified by CMS on a diagnosis-by-diagnosis basis depending on whether the condition was likely to have been affected by the LEJR procedure and recovery period or whether substantial services were likely to be provided for the chronic condition during the episode. Such chronic disease diagnoses are posted on the CMS Web site and may be revised in accordance with paragraph (e) of this section.

(iii) Certain PBPM payments under models tested under section 1115A of the Act. PBPM model payments that CMS determines to be primarily used for care coordination or care management services for clinical conditions in excluded categories of diagnoses, as described in this paragraph.

(A) The list of excluded PBPM payments is posted on the CMS Web site and are revised in accordance with paragraph (e) of this section.

(B) Notwithstanding the foregoing, all PBPM model payments funded from CMS' Innovation Center appropriation are excluded from the episode.

(5) Certain incentive programs and add on payments under existing Medicare payment systems in accordance with § 510.300(b)(6) of this chapter.

(6) For performance years 1 through 4 and for performance year subsets 5.1 and 5.2, payments for otherwise included items and services in excess of 2 standard deviations above the mean regional episode payment in accordance with § 510.300(b)(5).

(e) Updating the lists of excluded services. (1) The list of excluded MS-DRGs, ICD-CM diagnosis codes, and CMS model PBPM payments are posted on the CMS Web site.

(2) On an annual basis, or more frequently as needed, CMS updates the list of excluded services to reflect annual coding changes or other issues brought to CMS's attention.

(3) CMS applies the following standards when revising the list of excluded services for reasons other than to reflect annual coding changes:

(i) Items or services that are directly related to the LEJR procedure or the quality or safety of LEJR care would be included in the episode.

(ii) Items or services for chronic conditions that may be affected by the LEJR procedure or post-surgical care would be related and included in the episode.

(iii) Items and services for chronic conditions that are generally not affected by the LEJR procedure or post-surgical care would be excluded from the episode.

(iv) Items and services for acute clinical conditions not arising from existing, episode-related chronic clinical conditions or complications of LEJR surgery would be excluded from the episode.

(v) PBPM payments under CMS models determined to be primarily used for care coordination or care management services for clinical conditions in excluded categories of diagnoses, as described in § 510.200(d), would be excluded from the episode.

(4) CMS posts the following to the CMS Web site:

(i) Potential revisions to the exclusion to allow for public comment; and

(ii) An updated exclusions list after consideration of public comment.