



Processing Services During Disenrollment from the Program of All-Inclusive Care for the Elderly

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Related CR Title: Instructions to Process Services During Disenrollment from the Program of All-Inclusive Care for the Elderly (PACE)

Affected Providers

- Hospitals
- Skilled nursing facilities
- Other providers billing Medicare Administrative Contractors (MACs) for inpatient services they provide to [PACE](#)-eligible Medicare patients

Action Needed

Make sure your billing staffs know about:

- How CMS handles payment for Medicare patients disenrolling from PACE
- Condition codes and value code (VC) we require to prevent claims denials

Background

CR 13248 supports language in Section 1862(a)(3) of the [Social Security Act](#), which states the Medicare Program won't pay for services or items that are paid directly or indirectly by another government entity. PACE-paid claims represent a Medicare exclusion rather than an indication of Medicare Secondary Payer.

We're prohibited from paying claims for a Medicare patient enrolled for PACE benefits because Medicare paid the PACE for care of the patient.

PACE is an innovative model that provides a range of integrated preventative, acute care, and long-term care services managing the complex medical, functional, and social needs of the frail elderly. PACE provides clients, family, caregivers, and professional health care providers the flexibility to meet a person's health care needs while continuing to live safely in the community.

PACE isn't a Medicare Advantage (MA) plan but has certain fundamental similarities to MA and

managed care organizations.

We use the Medicare Secondary Payer PAY module to process claims for PACE-entitled inpatients when admissions span 2 months and 1 of the months was covered by the PACE, but the patient disenrolls from PACE before discharge from the inpatient admission.

When a PACE patient is an inpatient and disenrolls from PACE during the stay, you must use:

- Condition code 35, showing the patient is a PACE patient who disenrolled during an inpatient stay
- VC 42 showing the amount of the PACE payment made on behalf of a Medicare patient that the provider is applying to Medicare charges on this bill.

If the PACE doesn't approve all the services due to disenrollment from the program, you may bill any Medicare covered services not considered by the PACE program to Medicare.

You can use condition code 35 with VC 42 and primary payer code I on inpatient claims with type of bill (TOB) codes 11X, 18X, 21X, and 41X. We'll only allow an inpatient claim with these TOBs and condition code 35 when a valid HMO ID for a PACE plan is present on the patient's record, and the cancel date of the ID overlaps the admission date on the incoming claim.

We'll return claims to you that have:

- Condition code 35 without VC 42
- VC 42 without condition code 35 or 26
- VC 42 present with condition code 35 but the VC 42 has a value of all zeros

More Information

We issued CR 13248 to your MAC as the official instruction for this change.

For more information, [find your MAC's website](#).

Document History

Date of Change	Description
July 21, 2023	Initial article released.

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