CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3721	Date: February 24, 2017
	Change Request 9906

SUBJECT: Updates to Pub. 100-04, Chapters 12, 17 and 23 to Correct Remittance Advice Messages

I. SUMMARY OF CHANGES: This Change Request revises chapters 12, 17, and 23 of the Medicare Claims Processing Manual to ensure that all remittance advice coding is consistent with national standard operating rules. It also provides a format for consistently showing remittance advice coding throughout this manual.

EFFECTIVE DATE: May 25, 2017
*Unless otherwise specified, the effective date is the date of service.
IMPLEMENTATION DATE: May 25, 2017

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
R	12/40.4/Adjudication of Claims for Global Surgeries
R	12/40.8/Claims for Co-Surgeons and Team Surgeons
R	12/190.7/ Contractor Editing of Telehealth Claims
R	12/40.5/Postpayment Issues
R	12/220/Chiropractic Services
R	17/50/Assignment Required for Drugs and Biologicals
R	17/60.1/Prescription Drugs Billed by Suppliers Not Licensed to Dispense Them
R	17/80.1.4/ MSN/Claim Adjustment Message Codes for Oral Cancer Drug Denials
R	17/80.2.3/ MSN Denial /Claim Adjustment and Remark Messages for Anti-Emetic Drugs
R	17/80.3.2/ MSN/Remittance Messages for Immunosuppressive Drugs
R	17/80.8/Reporting of Hematocrit and/or Hemoglobin Levels
R	17/80.9/ Required Modifiers for ESAs Administered to Non-ESRD Patients
R	17/80.12 /Claims Processing Rules for ESAs Administered to Cancer Patients for Anti-Anemia Therapy
R	17/100.2.1/CAP Required Modifiers
R	17/100.2.3/ Submitting the Prescription Order Numbers and No Pay Modifiers
R	17/100.2.3.1/ Further Editing on the Prescription Order Number
R	17/100.2.4/CAP Claims Submitted With Only the No Pay Line
R	17/100.2.8/Claims Submitted for Only Drugs Listed on the Approved CAP Vendor's Drug List
R	17/100.4.1/Creation of Internal Vendor Provider Files
R	17/100.4.2/Submission of Paper Claims by Vendors
R	17/100.4.3/Submission of Claims from Vendors With the J1 No Pay Modifier
R	17/100.4.4/Submission of Claims from Vendors Without a Provider Primary Identifier for the Ordering Physician
R	17/100.5.1/ Denials Due to Medical Necessity
R	17/100.5.2/ Denials For Reasons Other Than Medical Necessity
R	17/100.5.6/ Creation of a Weekly Report for Claims That Have Pended More Than 90 Days and Subsequent Action
R	17/100.8.3.1/ Editing for CAP NOC Drugs

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	23/20.9/ Correct Coding Initiative (CCI)
R	23/20.9.1.1/ Instructions for Codes With Modifiers (A/B MACs (B) Only)

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:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3721	Date: February 24, 2017	Change Request: 9906

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I.   GENERAL INFORMATION

A.   Background: Section 1171 of the Social Security Act requires a standard set of operating rules to regulate the health insurance industry's use of electronic data interchange (EDI) transactions. Operating Rule 360: Uniform Use of CARCs and RARCs, regulates the way in which group codes, claims adjustment reason codes (CARCs) and remittance advice remark codes (RARCs) may be used. The rule requires specific codes which are to be used in combination with one another if one of the named business scenarios applies. This rule is authored by the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE).

Medicare and all other payers must comply with the CAQH CORE-developed code combinations. The business scenario for each payment adjustment must be defined, if applicable, and a valid code combination selected for all remittance advice messages. This CR updates chapters 12,17 and 23 of the manual to reflect the standard format and to correct any non-compliant code combinations. Additional CRs will follow to provide similar revisions to the remaining chapters of Pub. 100-04.

B.   Policy: Remittance coding used by Medicare Administrative Contractors shall be compliant with nationally standard CAQH/CORE operating rules.

II.   BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			D M E MAC	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
9906.1	The contractor shall ensure that it applies remittance advice coding as described in the revised instructions in Pub. 100-04, chapter 12.	X	X		X					
9906.2	The contractor shall ensure that it applies remittance advice coding as described in the revised instructions in Pub. 100-04, chapter 17.	X	X		X					
9906.3	The contractor shall ensure that it applies remittance	X	X		X					

Number	Requirement	Responsibility								
		A/B MAC			D M E	Shared-System Maintainers				Other
		A	B	H H H	M A C	F I S S	M C S	V M S	C W F	
	advice coding as described in the revised instructions in Pub. 100-04, chapter 23.									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E	C E D I
		A	B	H H H	M A C	
9906.4	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X		X	

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"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): Wil Gehne, Wilfried.Gehne@cms.hhs.gov , Teira Canty, Teira.Canty@cms.hhs.gov , Brian Reitz, Brian.Reitz@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: 0

Medicare Claims Processing Manual
Chapter 12 - Physicians/Nonphysician Practitioners

Table of Contents
(Rev .3721, Issued: 02-24-17)

40.4 - Adjudication of Claims for Global Surgeries
(Rev. 3721, Issued: 02-24-17, Effective: 05-25-17, Implementation: 05-25-17)

A. Fragmented Billing of Services Included in the Global Package

Since the Medicare fee schedule amount for surgical procedures includes all services that are part of the global surgery package, A/B MACs (B) do not pay more than that amount when a bill is fragmented. When total charges for fragmented services exceed the global fee, process the claim as a fee schedule reduction (except where stated policies, e.g., the surgeon performs only the surgery and a physician other than the surgeon provides preoperative and postoperative inpatient care, result in payment that is higher than the global surgery allowed amount). A/B MACs (B) do not attribute such reductions to medical review savings except where the usual medical review process results in recoding of a service, and the recoded service is included in the global surgery package.
The maximum a nonparticipating physician may bill a beneficiary on an unassigned claim for services included in the global surgery package is the limiting charge for the surgical procedure.

In addition, the limitation of liability provision (§1879 of the Act) does not apply to these determinations since they are fee schedule reductions, not denials based upon medical necessity or custodial care.

Claims for surgeries billed with a "-22" or "-52" modifier, are priced by individual consideration if the statement and documentation required by §40.2.A.10 are included. If the statement and documentation are not submitted with the claim, pricing for "-22" is it the fee schedule rate for the same surgery submitted without the "-22" modifier. Pricing for "-52" is not done without the required documentation.

Separate payment is allowed for visits and procedures billed with modifier "-78," "-79," "-24," "-25," "-57," or "-58." Modifier "-24" must be accompanied by sufficient documentation that the visit is unrelated to the surgery. Also, when used with the critical care codes, modifiers "-24" and "-25" must be accompanied by documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed.

A/B MACs (B) do not allow separate payment for evaluation and management services furnished on the same day or during the postoperative period of a surgery if the services are billed without modifier "-24," "-25," or "-57." These services should be denied. A/B MACs (B) do not allow separate payment for visits during the postoperative period that are billed with the modifier "-24" but without sufficient documentation. These services should also be denied. Modifier "-24" is intended for use with services that are absolutely unrelated to the surgery. It is not to be used for the medical management of a patient by the surgeon following surgery. Recognize modifier "-24" only for care following discharge unless:

- The care is for immunotherapy management furnished by the transplant surgeon;

- The care is for critical care for a burn or trauma patient; or

- The documentation demonstrates that the visit occurred during a subsequent hospitalization and the diagnosis supports the fact that it is unrelated to the original surgery.

A/B MACs (B) do not allow separate payment for an additional procedure(s) with a global surgery fee period if furnished during the postoperative period of a prior procedure and if billed without modifier "-58," "-78," or "-79." These services should be denied. Codes with the global surgery indicator of "XXX" in the MFSDB can be paid separately without a modifier.

B. Claims From Physicians Who Furnish Less Than the Global Package (Split Global Care)

For surgeries performed January 1, 1992, and later, that are billed with either modifier "-54" or "-55," A/B MACs (B) pay the appropriate percentage of the fee schedule payment. Fields 17-19 of the MFSDB list the appropriate percentages for pre-, intra-, and postoperative care of the total RVUs for major surgical procedures and for minor surgeries with a postoperative period of 10 days. The intra-operative percentage includes postoperative hospital visits.

Procedures with a "000" entry in Field 16 have an entry of "0.0000" in Fields 17-19. Split global care does not apply to these procedures.

A/B MACs (B) multiply the fee schedule amount (Field 34 or Field 35 of the MFSDB) by this percentage and round to the nearest cent. Assume that a physician who bills with a "-54" modifier has provided both preoperative, intra-operative and postoperative **hospital** services. Pay this physician the combined preoperative and intra-operative portions of the fee schedule payment amount.

Where more than one physician bills for the postoperative care, A/B MACs (B) apportion the postoperative percentage according to the number of days each physician was responsible for the patient's care by dividing the postoperative allowed amount by the number of post-op days and that amount is multiplied by the number of days each physician saw the patient.

EXAMPLE

Dr. Jones bills for procedure "42145-54" performed on March 1 and states that he cared for the patient through April 29. Dr. Smith bills for procedure "42145-55" and states that she assumed care of the patient on April 30. The percentage of the total fee amount for the postoperative care for this procedure is determined to be 17 percent and the length of the global period is 90 days. Since Dr. Jones provided postoperative care for the first 60 days, he will receive 66 2/3 percent of the total fee of 17 percent since 60/90 = .6666. Dr. Smith's 30 days of service entitle her to 30/90 or .3333 of the fee.

> 6666 x .17 = .11333 or 11.3%; and
>
> 3338 x .17 = .057 or 5.7%.

Thus, Dr. Jones will be paid at a rate of 11.3 percent (66.7 percent of 17 percent). Dr. Smith will be paid at a rate of 5.7 percent (33.3 percent of 17 percent).

C. Payment for Return Trips to the Operating Room for Treatment of Complications

When a CPT code billed with modifier "-78" describes the services involving a return trip to the operating room to deal with complications, A/B MACs (B) pay the value of the intra-operative services of the code that describes the treatment of the complications. Refer to Field 18 of the MFSDB to determine the percentage of the global package for the intra-operative services. The fee schedule amount (Field 34 or 35 of the MFSDB) is multiplied by this percentage and rounded to the nearest cent.

When a procedure with a "000" global period is billed with a modifier "-78," representing a return trip to the operating room to deal with complications, A/B MACs (B) pay the full value for the procedure, since these codes have no pre-, post-, or intra-operative values.

When an unlisted procedure is billed because no code exists to describe the treatment for complications, A/B MACs (B) base payment on a maximum of 50 percent of the value of the intra-operative services originally

performed. If multiple surgeries were originally performed, A/B MACs (B) base payment on no more than 50 percent of the value of the intra-operative services of the surgery for which the complications occurred. They multiply the fee schedule amount for the original surgery (Field 34 or 35) by the intra-operative percentage for the procedure (Field 18), and then multiply that figure by 50 percent to obtain the maximum payment amount.

[.50 X (fee schedule amount x intra-operative percentage)]. Round to the nearest cent.

If additional procedures are performed during the same operative session as the original surgery to treat complications which occurred during the original surgery, A/B MACs (B) pay the additional procedures as multiple surgeries. Only surgeries that require a return to the operating room are paid under the complications rules.

If the patient is returned to the operating room after the initial operative session, but on the same day as the original surgery for one or more additional procedures as a result of complications from the original surgery, the complications rules apply to each procedure required to treat the complications from the original surgery. The multiple surgery rules would not also apply.

If the patient is returned to the operating room during the postoperative period of the original surgery, not on the same day of the original surgery, for multiple procedures that are required as a result of complications from the original surgery, the complications rules would apply. The multiple surgery rules would also not apply.
If the patient is returned to the operating room during the postoperative period of the original surgery, not on the same day of the original surgery, for bilateral procedures that are required as a result of complications from the original surgery, the complication rules would apply. The bilateral rules would not apply.

D. MSN and Remittance Messages

When A/B MACs (B) deny separate payment for a visit because it is included in the global package, include one of the following statements on the MSN to the beneficiary and the remittance notice sent to the physician.

1. Messages for Fragmented Billing by a Single Physician

When a single physician bills separately for services included in the global surgical package *which has already been billed:*

The following reflects the remittance advice messages and associated codes that will appear when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario 4.

Group Code: CO

CARC: 97

RARC: N/A

MSN: 23.1

When a single physician bills separately for services included in the global surgical package which has not yet been billed/adjudicated:

Group Code: CO

CARC: B15

RARC: N/A

MSN: 23.1

2. Messages for Global Packages Split Between Two or More Physicians

When a physician furnishes only the pre- and intra-operative services, but bills for the entire package:

Group Code: CO

CARC: B20

RARC: N/A

MSN: 23.5

3. Message for Procedure Codes With "ZZZ" Global Period Billed as Stand-Alone Procedures

When a physician bills for a surgery with a "ZZZ" global period without billing for another service:

Group Code: CO

CARC: 234

RARC: N390

MSN: 9.2, 9.3

4. Message for Payment Amount When Modifier "-22" Is Submitted Without Documentation

When a physician submits a claim with modifier "-22" but does not provide additional documentation:

Group Code: CO

CARC: 252

RARC: N706

MSN: 9.7

40.5 - Postpayment Issues
(Rev. 3721, Issued: 02-24-17, Effective: 05-25-17, Implementation: 05-25-17)

It may not always be possible to identify instances where more than one physician furnishes postoperative care before the carrier has paid at least one of the physicians. In addition, situations where a physician renders less than the full global package but does not add the applicable modifier to the procedure code are not detectable until another physician submits a claim.

Several other categories of fragmented bills cannot be or are difficult to detect on a prepayment basis. When a new claim reveals fragmented billing by a single provider after payment for some services was already made to that physician, carriers must adjust the amount due on the new claim by the amount previously paid.

When a new claim indicates that an incorrect payment may have been made to another physician who submitted a previous bill, carriers must determine which bill is correct. (Review the claims and any submitted records to be sure that the providers correctly used modifiers and are billing for services that are included in the global fee. If necessary, a carrier representative must contact one or both physicians to determine which claim is correct.) If the carrier determines that the first claim is incorrect, they follow the overpayment procedures in the Medicare Financial Management Manual, Chapter 3, for recovery of the incorrect payment from the first physician. They pay the second physician according to the services performed. If the carrier determines that the second claim is incorrect, they deny payment.

The following reflects the remittance advice messages and associated codes that will appear when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario 3.

Group Code: CO

CARC: B20

RARC: N/A

MSN: 7.3

Carriers must include the appropriate language regarding beneficiary liability according to §40.4.D, above.

Nonparticipating physicians who furnish less than the full global package, but who bill for the entire global surgery, may be guilty of violating their charge limits. In addition, physicians who engage in such practices may be guilty of fraud. See the Medicare Financial Management Manual, Chapter 3, and the Medicare Program Integrity Manual, Chapter 3, for further information on recovery of overpayments, charge limit monitoring, and fraud.

40.8. Claims for Co-Surgeons and Team Surgeons

A. General

Under some circumstances, the individual skills of two or more surgeons are required to perform surgery on the same patient during the same operative session. This may be required because of the complex nature of the procedure(s) and/or the patient's condition. In these cases, the additional physicians are not acting as assistants-at-surgery.

B. Billing Instructions

The following billing procedures apply when billing for a surgical procedure or procedures that required the use of two surgeons or a team of surgeons:

- If two surgeons (each in a different specialty) are required to perform a specific procedure, each surgeon bills for the procedure with a modifier "-62." Co-surgery also refers to surgical procedures involving two surgeons performing the parts of the procedure simultaneously, i.e., heart transplant or bilateral knee replacements. Documentation of the medical necessity for two surgeons is required for certain services identified in the MFSDB. (See §40.8.C.5.);

- If a team of surgeons (more than 2 surgeons of different specialties) is required to perform a specific procedure, each surgeon bills for the procedure with a modifier "-66." Field 25 of the MFSDB identifies certain services submitted with a "-66" modifier which must be sufficiently documented to establish that a team was medically necessary. All claims for team surgeons must contain sufficient information to allow pricing "by report."

- If surgeons of different specialties are each performing a different procedure (with specific CPT codes), neither co-surgery nor multiple surgery rules apply (even if the procedures are performed through the same incision). If one of the surgeons performs multiple procedures, the multiple procedure rules apply to that surgeon's services. (See §40.6 for multiple surgery payment rules.)

For co-surgeons (modifier 62), the fee schedule amount applicable to the payment for **each** co-surgeon is 62.5 percent of the global surgery fee schedule amount. Team surgery (modifier 66) is paid for on a "By Report" basis.

C. Claims Processing System Requirements

Carriers must be able to:

1. Identify a surgical procedure performed by two surgeons or a team of surgeons by the presence on the claim form or electronic submission of the "-62" or "-66" modifier;

2. Access Field 34 or 35 of the MFSDB to determine the fee schedule payment amount for the surgery;

3. Access Field 24 or 25, as appropriate, of the MFSDB. These fields provide guidance on whether two or team surgeons are generally required for the surgical procedure;

4. If the surgery is billed with a "-62" or "-66" modifier and Field 24 or 25 contains an indicator of "0," payment adjustment rules for two or team surgeons do not apply:

    - Carriers pay the first bill submitted, and base payment on the lower of the billed amount or 100 percent of the fee schedule amount (Field 34 or 35) unless other payment adjustment rules apply;

    - Carriers deny bills received subsequently from other physicians and use the appropriate MSN message in §§40.8.D. As these are medical necessity denials, the instructions in the Program Integrity Manual regarding denial of unassigned claims for medical necessity are applied;

5. If the surgery is billed with a "-62" modifier and Field 24 contains an indicator of "1," suspend the claim for manual review of any documentation submitted with the claim. If the documentation supports the need for co-surgeons, base payment for each physician on the lower of the billed amount or 62.5 percent of the fee schedule amount (Field 34 or 35);

6. If the surgery is billed with a "-62" modifier and Field 24 contains an indicator of "2," payment rules for two surgeons apply. Carriers base payment for each physician on the lower of the billed amount or 62.5 percent of the fee schedule amount (Field 34 or 35);

7. If the surgery is billed with a "-66" modifier and Field 25 contains an indicator of "1," carriers suspend the claim for manual review. If carriers determine that team surgeons were medically necessary, each physician is paid on a "by report" basis;

8. If the surgery is billed with a "-66" modifier and Field 25 contains an indicator of "2," carriers pay "by report";

    NOTE: A Medicare fee may have been established for some surgical procedures that are billed with the "-66" modifier. In these cases, all physicians on the team must agree on the percentage of the Medicare payment amount each is to receive. If carriers receive a bill with a "-66" modifier after carriers have paid one surgeon the full Medicare payment amount (on a bill **without** the modifier), deny the subsequent claim.

9. Apply the rules global surgical packages to each of the physicians participating in a co- or team surgery; and

10. Retain the "-62" and "-66" modifiers in history for any co- or team surgeries.

D. Beneficiary Liability on Denied Claims for Assistant, Co- surgeon and Team Surgeons

When the procedure is subject to the statutory restriction against payment for assistants-at-surgery, such payment shall be denied.

> *The following reflects the remittance advice messages and associated codes that will appear when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario 3.*

> *Group Code: CO*

> *CARC: 54*

> *RARC: N/A*

> *MSN: 15.11*

Carriers include the following statement in the MSN:

> *"You cannot be charged for this service." (Unnumbered add-on message.)*

If Field 23 of the MFSDB contains an indicator of "0" or "1" (assistant-at-surgery may not be paid) for procedures CMS has determined that an assistant surgeon is not generally medically necessary.

> *The following reflects the remittance advice messages and associated codes that will appear when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario 3.*

> *Group Code: CO*

> *CARC: 54*

> *RARC: N/A*

For those procedures with an indicator of "0," the limitation on liability provisions described in Chapter 30 apply to assigned claims. Therefore, carriers include the appropriate limitation of liability language from Chapter 21. For unassigned claims, apply the rules in the Program Integrity Manual concerning denial for medical necessity.

Where payment may not be made for a co- or team surgeon, *deny the claim*

The following reflects the remittance advice messages and associated codes that will appear when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario 3.

Group Code: CO

CARC: 54

RARC: N/A

MSN: 15.13

Where payment may not be made for a two surgeons, *deny the claim.*

The following reflects the remittance advice messages and associated codes that will appear when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario 3.

Group Code: CO

CARC: 54

RARC: N/A

MSN: 15.12

Also see limitation of liability remittance notice *Remittance Advice Remark Code Alert* M27 *and use when appropriate*.

90.4.6 – Reserved for Future Use

190.7 - Contractor Editing of Telehealth Claims

(Rev. 3721, Issued: 02-24-17, Effective: 05-25-17, Implementation: 05-25-17)

Medicare telehealth services (as listed in section 190.3) are billed with either the "GT" or "GQ" modifier. The contractor shall approve covered telehealth services if the physician or practitioner is licensed under State law to provide the service. Contractors must familiarize themselves with licensure provisions of States for which they process claims and disallow telehealth services furnished by physicians or practitioners who are not authorized to furnish the applicable telehealth service under State law. For example, if a nurse practitioner is not licensed to provide individual psychotherapy under State law, he or she would not be permitted to receive payment for individual psychotherapy under Medicare. The contractor shall install edits to ensure that only properly licensed physicians and practitioners are paid for covered telehealth services.

If a contractor receives claims for professional telehealth services coded with the "GQ" modifier (representing "via asynchronous telecommunications system"), it shall approve/pay for these services only if the physician or practitioner is affiliated with a Federal telemedicine demonstration conducted in Alaska or Hawaii. The contractor may require the physician or practitioner at the distant site to document his or her participation in a Federal telemedicine demonstration program conducted in Alaska or Hawaii prior to paying for telehealth services provided via asynchronous, store and forward technologies.

Contractors shall deny telehealth services if the physician or practitioner is not eligible to bill for them.

> *The following reflects the remittance advice messages and associated codes that will appear when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario 3.*
>
> *Group Code: CO*
>
> *CARC: 185*
>
> *RARC: N/A*
>
> *MSN: 21.18*

If a service is billed with one of the telehealth modifiers and the procedure code is not designated as a covered telehealth service, the contractor denies the service.

> *The following reflects the remittance advice messages and associated codes that will appear when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario 3.*
>
> *Group Code: CO*
>
> *CARC: 96*
>
> *RARC: N776*
>
> *MSN: 9.4*

The only claims from institutional facilities that FIs shall pay for telehealth services at the distant site, except for MNT services, are for physician or practitioner services when the distant site is located in a CAH that has elected Method II, and the physician or practitioner has reassigned his/her benefits to the CAH. The CAH bills its regular FI for the professional services provided at the distant site via a telecommunications system, in any of the revenue codes 096x, 097x or 098x. All requirements for billing distant site telehealth services apply.

Claims from hospitals or CAHs for MNT services are submitted to the hospital's or CAH's regular FI. Payment is based on the non-facility amount on the Medicare Physician Fee Schedule for the particular HCPCS codes.

220 – Chiropractic Services

(Rev. 3721, Issued: 02-24-17, Effective: 05-25-17, Implementation: 05-25-17)

A. Verification of Chiropractor's Qualifications

Establish a reference file of chiropractors eligible for payment as physicians under the criteria in Pub. 100-02, Benefits Policy Manual, Chapter 15, Sections 30.5 & 240A. Pay only chiropractors on file. Information needed to establish such files is furnished by the RO.

The RO is notified by the appropriate State agency which chiropractors are licensed and whether each meets the national uniform standards.

B. Durable Medical Equipment Regional Carriers Processing Claims When a Chiropractor is the Supplier

Effective July 1, 1999, except for restrictions to chiropractor services as stipulated in §§1861(s)(2)(A) of the Social Security Act, chiropractors (specialty 35) can bill for durable medical equipment, prosthetics, orthotics and supplies if, as the supplier, they have a valid supplier number assigned by the National Supplier Clearinghouse. In order to process claims, the Common Working File has been changed to allow specialty 35 to bill for services furnished as a supplier.

C. Documentation

The following information must be recorded by the chiropractor and kept on file. The date of the initial treatment or date of exacerbation of the existing condition must be entered in Item 14 of Form CMS-1500. This serves as affirmation by the chiropractor that all documentation required as listed below and in Pub. 100-02, Benefits Policy Manual, Chapter 15, Section 240.1.2 is being maintained on file by the chiropractor.

      1.   Specification of the precise spinal location and level of subluxation (see Pub. 100-02, Benefits Policy Manual, Chapter 15, Section 240.1.4) giving rise to the diagnosis and symptoms.

      2.   Effective for claims with dates of service on and after January 1, 2000, the x-ray is no longer required. However, the x-ray may still be used to demonstrate subluxation for claims processing purposes. Effective for claims with dates of service on or after October 1, 2000, when the x-ray is used to demonstrate subluxation, the date of the x-ray must be entered in Item 19 of Form CMS-1500 and the date must be within the parameters specified in Pub. 100-02, Benefits Policy Manual, Chapter 15, Section 240.1.2.

For claims with dates of service prior to January 1, 2000, and for claims with dates of service on or after October 1, 2000, for which an x-ray is still used to show subluxation, the following instructions on documentation apply:

An x-ray film (including the date of the film) is available for your review demonstrating the existence of a subluxation at the specified level of the spine. If the beneficiary refuses to have the x-ray, the chiropractor must submit one of the appropriate HCPCS codes for chiropractic manipulation in addition to modifier GX (service not covered by Medicare), and the claim will be denied as a technical denial.

The following reflects the remittance advice messages and associated codes that will appear when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario 3.

Group Code: PR

CARC: 96

RARC: M111

MSN: 3.1

NOTE: The refusal of the beneficiary to have an x-ray taken will no longer need to be coded for claims with dates of service on or after January 1, 2000.

D. Claims Processing

Edits and suggested MSN and RA messages.

     1. Do not pay for manual manipulation of the spine in treating conditions other than those indicated in Pub. 100-02, Benefits Policy Manual, Chapter 15, Section 240.1.3.

The following reflects the remittance advice messages and associated codes that will appear when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario 3.

Group Code: CO

CARC: 50

RARC: N/A

MSN: 15.4

     2. Deny claims for treatment of any condition not reasonably related to a subluxation involving vertebrae at the spinal level specified.

The following reflects the remittance advice messages and associated codes that will appear when rejecting/denying claims under this policy. The CARC below is not included in the CAQH CORE Business Scenarios.

Group Code: CO

CARC: B22

RARC: N/A

MSN: 15.4

     3. Edit to verify that the date of the initial visit or the date of exacerbation of the existing condition is entered.

The following reflects the remittance advice messages and associated codes that will appear when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario 2.

Group Code: CO

CARC: 16

RARC: MA122

MSN: 9.2

E. X-ray Review

Effective for claims with dates of service on and after January 1, 2000, the x-ray is no longer required. However, effective for claims with dates of service on or after October 1, 2000, should the chiropractor choose to use the x-ray to show subluxation, the x-ray review process is still required as outlined below minus the requirement in the last sentence of number 2. For claims with dates of service prior to January 1, 2000, all aspects of the following instructions still apply.

      1.   Carriers should conduct post-payment reviews of x-rays on a sample basis. Prepayment review should be undertaken in all questionable cases.

      2.   It is the responsibility of the treating chiropractor to make the documenting x-ray(s) available to the carrier's review staff. If x-rays are not made available, or suggest a pattern in failing to demonstrate subluxation for any reason, including unacceptable technical quality, the carrier should conduct prepayment review of x-rays in 100 percent of the subsequent claims for treatments by the practitioner involved until satisfied that the deficiency will no longer occur. Where there is no x-ray documentation of subluxation on prepayment review, the claims, of course, should be denied. (The last sentence of this paragraph only refers to claims with dates of service prior to January 1, 2000.)

      3.   The x-ray film(s) must have been taken at a time reasonably proximate to the initiation of the course of treatment and must demonstrate a subluxation at the level of the spine specified by the treating chiropractor on the claim. (See Pub. 100-02, Benefits Policy Manual, Chapter 15, Section 240.1.2.)

      4.   An x-ray obtained by the chiropractor for his own diagnostic purposes before commencing treatment should suffice for claims documentation purposes. However, when subluxation was for treatment purposes diagnosed by some other means and x-rays are taken to satisfy Medicare's documentation requirement, carriers should ask chiropractors to hone in on the site of the subluxation in producing x-rays. Such a practice would not only minimize the exposure of the patient but also should result in a film more clearly portraying the subluxation.

      5.   An x-ray will be considered of acceptable technical quality if any individual trained in the reading of x-rays could recognize a subluxation if present.

      6.   When claims have been denied because the x-ray(s) initially offered failed to document the existence of a subluxation requiring treatment, no review of these decisions should be undertaken on the basis of x-ray(s) subsequently taken. Permitting such reviews could be an inducement to excessive exposure of patients to radiation in cases where the decision to treat was made despite x-rays that did not show a subluxation.

Medicare Claims Processing Manual
Chapter 17 - Drugs and Biologicals

50 - Assignment Required for Drugs and Biologicals
(Rev. 3721, Issued: 02-24-17, Effective: 05-25-17, Implementation: 05-25-17)

A. A/B MACs (B)

Under §114 of the Benefits Improvement Act of 2000, effective for claims with dates of service on or after February 1, 2001, payment for any drug or biological covered under Part B of Medicare may be made only on an assignment-related basis. Therefore, no charge or bill may be rendered to anyone for these drugs and biologicals for any amount except for any applicable unmet Medicare Part B deductible and coinsurance amounts. All entities (including physicians, nonphysician practitioners, pharmacies and suppliers) that bill Medicare for drugs and biologicals must take assignment on all claims for drugs and biologicals furnished to any beneficiary enrolled in Medicare Part B. Contractors apply this policy to all items paid based on the lower of the actual charge on the claim or 95 percent of the AWP. See §§20 for a description of the AWP.

Mandatory assignment does not apply to HCPCS code E0590, which represents the dispensing fee for nebulizer drugs.

A/B MACs (B) process all claims for drugs and biologicals with a date of service on or after February 1, 2001, as though the physician or nonphysician practitioner had taken assignment. If only drugs and biologicals are billed on the claim, and the claim was submitted as unassigned, contractors change the claim to assigned and process as an assigned claim. If a physician or nonphysician practitioner submits an unassigned claim that contains both codes for drugs or biologicals and codes for other services, A/B MACs (B) split the claim into two claims. The first claim will be an unassigned claim for services other than drugs or biologicals, and the second will be an assigned claim for drugs or biologicals furnished on or after February 1, 2001. The following messages apply when an A/B MAC (B) has changed the claim to assigned status (regardless of whether the contractor had to split the claim):

The contractor shall use the following remittance advice messages and associated codes when adjusting payment under this policy. The RARC below is not included in the CAQH CORE Business Scenarios.

Group Code: N/A
CARC: N/A
RARC: MA72
MSN: 16.50

Additional appropriate message for physicians, suppliers, and beneficiaries should be added as necessary.

B. DME MACs

Under §114 of BIPA, DMEPOS suppliers must accept assignment on all claims for drugs and biologicals that they bill to the DME MACs. A supplier may not render a charge or bill to anyone for these drugs and biologicals for any amount other than the Medicare Part B deductible and coinsurance amounts.

Mandatory assignment does not apply to HCPCS code E0590, which represents the dispensing fee for nebulizer drugs.

The DME MACs must inform suppliers on their Web sites and in their next bulletins that they must accept assignment on claims for drugs and biologicals furnished on or after February 1, 2001.

The DME MACs must deny any claims a beneficiary submits for drugs and biologicals with dates of service on or after February 1, 2001. The DME MACs must notify beneficiaries that suppliers must accept assignment on claims for drugs and biologicals, and therefore, the beneficiaries may not submit claims for drugs and biologicals. When denying beneficiary-submitted claims, DME MACs use the following Medicare Summary Notice (MSN) messages:

MSN 16.6 (English): "This item or service cannot be paid unless the provider accepts assignment."

MSN 16.6 (Spanish): "Este artículo o servicio no se pagará a menos de que el proveedor acepte asignación."

MSN 16.7 (English): "Your provider must complete and submit your claim."

MSN 16.7 (Spanish): "Su proveedor debe completar y someter su reclamación."

MSN 16.34 (English): "You should not be billed for this service. You do not have to pay this amount."

MSN 16.34 (Spanish): "Usted no debería ser facturado por este servicio. Usted no tiene que pagar esta cantidad."

MSN 16.36 (English): "If you have already paid it, you are entitled to a refund from this provider."

MSN 16.36 (Spanish): "Si usted ya lo ha pagado, tiene derecho a un reembolso de su proveedor."

If a supplier submits an unassigned claim with a date of service on or after February 1, 2001, to the DME MAC for a drug or biological, the DME MAC must process the claim as though the supplier accepted assignment. It is possible that a supplier may bill drugs and other items on the same claim, which would result in a claim with some assigned and some nonassigned items.

In the event that a supplier bills an unassigned claim to a DME MAC that contains both codes for drugs or biologicals and codes for other items, the DME MACs must replicate the claim. This will result in two claims in the DME MAC system: an unassigned claim for items other than drugs or biologicals, and an assigned claim for drugs and biologicals furnished on or after February 1, 2001. When a DME MAC changes an unassigned drug claim to an assigned claim*, the contractor shall use the following remittance advice messages and associated codes when adjusting payment under this policy. The RARC below is not included in the CAQH CORE Business Scenarios*
Group Code: N/A
CARC: N/A
RARC: MA72
MSN: N/A

Suppliers that bill the DME MACs for drugs for use with DMEPOS must have a pharmacy license to dispense drugs. When a DME MAC denies a claim for a drug because the National Supplier Clearing House (NSC) records do not show that the supplier has a pharmacy license, the DME MAC must also deny any equipment, accessories, and supplies related to the drug, when the supplier bills the drug on the same claim as the equipment. (Suppliers should bill drugs for use with DMEPOS on the same claim as the equipment itself, if they are also providing and billing for the equipment.) In situations when a supplier bills unassigned drugs and equipment, accessories, or supplies on the same claim, the DME MAC and VMS Shared System Maintainer must ensure that they apply nonlicensed pharmacy equipment, accessory and supply edits and denials before

they replicate the claim. Even if the system denies a line due to the nonlicensed pharmacy edit prior to replicating the claim, the system must still replicate any unassigned claims for drugs and biologicals and change the assignment indicator.

The contractor shall use the following remittance advice messages and associated codes when adjusting payment under this policy. The RARC below is not included in the CAQH CORE Business Scenarios.
Group Code: N/A
CARC: N/A
RARC: MA72
MSN: N/A

OR

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.
Group Code: CO
CARC: B7
RARC: M143
MSN: N/A

Or

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.
Group Code: CO
CARC: 107
RARC: N/A
MSN: N/A

The DME MACs must work together to create and maintain a list of HCPCS drug codes that suppliers must bill on an assigned basis. This will enable VMS shared system maintainer and the DME MACs to implement the necessary edits in their systems. Finally, the four DME MACs must work together to create a list of drug and equipment codes to which the nonlicensed pharmacy edit would apply in this situation. For this second list, the DME MACs need add only drugs that are used with equipment, and the equipment, and related supplies and accessories, that use those drugs, as opposed to all drugs that are subjected to the licensure edit. The DME MACs must share these lists with VMS shared system maintainer and CMS Central Office.

60.1 - Prescription Drugs Billed by Suppliers Not Licensed to Dispense Them
(Rev. 3721, Issued: 02-24-17, Effective: 05-25-17, Implementation: 05-25-17)

Medicare does not cover a drug used as a supply with DME or a prosthetic device if the drug is dispensed by an entity that is not licensed to dispense the drug. The drug is not considered to be reasonable and necessary because CMS cannot be assured of its safety and effectiveness unless it is dispensed by an entity that has a State license that qualifies it to dispense the drug. The equipment used with the drugs dispensed by a nonlicensed entity is also considered to be not reasonable and necessary because of the related safety and efficacy concerns. Physicians are considered to have been "deemed" the right to dispense prescription drugs, and therefore do not require a pharmacy license.

The DME MACs should deny claims for a prescription drug (and related equipment when billed on the same claim as the drug) when the National Supplier Clearinghouse's (NSC's) files show the supplier is or was not licensed to dispense the drugs on the date of service (DOS).

An exception to this general policy is oxygen claims.

Messages for Assigned Claims:

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.
Group Code: CO
CARC: B7
RARC: M143
MSN: 8.50

Messages for Nonassigned Claims:

> MSN: "This item or service is not covered when performed or ordered by this provider." (MSN #12.18)

Appeals should be addressed according to the instructions in Chapter 29.

80.1.4 - MSN/Claim Adjustment Message Codes for Oral Cancer Drug Denials
(Rev. 3721, Issued: 02-24-17, Effective: 05-25-17, Implementation: 05-25-17)

If the claim for an oral cancer drug is denied because it was not approved by FDA, is not considered to be a medically accepted treatment for cancer, or is not the chemical equivalent of a covered injectable cancer drug (or a covered Prodrug), use the appropriate message on the MSN.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.
Group Code: CO
CARC: 114
RARC: N/A
MSN: 6.2, 6.3

80.2.3 - MSN Denial /Claim Adjustment and Remark Messages for Anti-Emetic Drugs
(Rev. 3721, Issued: 02-24-17, Effective: 05-25-17, Implementation: 05-25-17)

If the claim for an anti-emetic drug is denied because FDA did not approve it, *the contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.*
Group Code: CO
CARC: 114
RARC: N/A
MSN: 6.2

If the claim for an anti-emetic drug is denied because the drug is not being used as part of an anticancer chemotherapeutic regimen, the contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.
Group Code: CO
CARC: 96
RARC: M100
MSN: 6.4

80.3.2 - MSN/Remittance Messages for Immunosuppressive Drugs
(Rev. 3721, Issued: 02-24-17, Effective: 05-25-17, Implementation: 05-25-17)

Remittance codes/messages for denied Immunosuppressive Drugs are as follows:

If the immunosuppressive drug is not approved by the FDA, contractor shall deny the claim. The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.
Group Code: CO
CARC: 114
RARC: N.A
MSN: 6.2

If the claim is denied because the benefit period has expired or because of the 30 day limitation, *the contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.*
Group Code: CO
CARC: 35
RARC: N.A
MSN: 4.3

If the claim is denied for the immunosuppressive drug because a transplant was not covered, *the contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.*
Group Code: CO
CARC: 107
RARC: N.A
MSN: N/A

80.8 - Reporting of Hematocrit and/or Hemoglobin Levels
(Rev. 3721, Issued: 02-24-17, Effective: 05-25-17, Implementation: 05-25-17)

Effective January 1, 2008, the following claims must report the most recent hematocrit or hemoglobin reading:

1. All claims billing for the administration of an ESA (HCPCS J0881, J0882, J0885, J0886 and Q4081).

2. All claims for the administration of a Part B anti-anemia drug (other than ESAs) used in the treatment of cancer that are not self-administered.

For institutional claims the hemoglobin reading is reported with a value code 48 and a hematocrit reading is reported with the value code 49. Claims not reporting a value code 48 or 49 will be returned to the provider.

For professional paper claims, test results are reported in item 19 of the Form CMS-1500 claim form. For electronic claims (ASC X12 837 professional claim format), providers report the hemoglobin or hematocrit readings in Loop 2400 MEA segment. The specifics are MEA01=TR (for test results), MEA02=R1 (for hemoglobin) or R2 (for hematocrit), and MEA03=the test results.

Effective for dates of service on and after January 1, 2008, contractors will return paper and electronic professional claims when the most recent hemoglobin or hematocrit test results are not reported.

80.9 - Required Modifiers for ESAs Administered to Non-ESRD Patients
(Rev. 3721, Issued: 02-24-17, Effective: 05-25-17, Implementation: 05-25-17)

Effective January 1, 2008, all non-ESRD claims billing HCPCS J0881 and J0885 must begin reporting one of the following modifiers:

> EA: ESA, anemia, chemo-induced
> EB: ESA, anemia, radio-induced
> EC: ESA, anemia, non-chemo/radio

Institutional claims that do not report one of the above modifiers will be returned to the provider.

Professional claims that are billed without the required modifiers will be returned as unprocessable.

ESAs administered for more than one of the indicated therapies are billed as separate line items (i.e., ESAs for chemo-induced anemia (EA modifier) are reported as separate line items (e.g., J0881EA); ESAs for radio-induced anemia (EB modifier) are reported as separate line items (e.g., J0885EB); ESAs for non-chemo/radio induced anemia (EC modifier) are reported as separate line items (e.g., J0881EC). Only one of the three ESA modifiers may be reported at the line item level.
 To return HCPCS J0881 or J0885 billed with more than one ESA modifier at the line item level, *the contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.*

80.12 - Claims Processing Rules for ESAs Administered to Cancer Patients for Anti-Anemia Therapy
(Rev. 3721, Issued: 02-24-17, Effective: 05-25-17, Implementation: 05-25-17)

The national coverage determination (NCD) titled, "The Use of ESAs in Cancer and Other Neoplastic Conditions" lists coverage criteria for the use of ESAs in patients who have cancer and experience anemia as a result of chemotherapy or as a result of the cancer itself. The full NCD can be viewed in Publication 100-03 of the NCD Manual, section 110.21.

Effective for claims with dates of service on and after January 1, 2008, non-ESRD ESA services for HCPCS J0881 or J0885 billed with modifier EC (ESA, anemia, non-chemo/radio) shall be denied when any one of the following diagnosis codes is present on the claim:

ICD-9-CM Applicable

- any anemia in cancer or cancer treatment patients due to folate deficiency (281.2),
- B-12 deficiency (281.1, 281.3),
- iron deficiency (280.0-280.9),
- hemolysis (282.0, 282.2, 282.9, 283.0, 283.2, 283.9-283.10, 283.19), or
- bleeding (280.0, 285.1),
- anemia associated with the treatment of acute and chronic myelogenous leukemias (CML, AML) (205.00-205.21, 205.80-205.91); or
- erythroid cancers (207.00-207.81).

ICD-10-CM Applicable

- any anemia in cancer or cancer treatment patients due to folate deficiency - (D52.0, D52.1, D52.8, or D52.9),
- B-12 deficiency - (D51.1, D51.2, D51.3, D51.8, D51.9, or D53.1),
- iron deficiency - (D50.0, D50.1, D50.8, and D50.9),
- hemolysis - (D55.0, D55.1, D58.0, D58.9, D59.0, D59.1, D59.2, D59 4, D59.5, D59.6, D59.8, or D59.9),
- bleeding - (D50.0, D62),
- anemia associated with the treatment of acute and chronic myelogenous leukemias (CML, AML) - (C92.00, C92.01, C92.02, C92.10, C92.11, C92.12, C92.20, C92.21, C92.40, C92.41, C92.42, C92.50, C92.51, C92.52, C92.60, C92.61, C92.62, C92.90, C92.91, C92.A0, C92.A1, C92.A2, C92Z0, C92Z1, or C92Z2), or
- erythroid cancers - (C94.00, C94.01, C94.02, C94.20, C94.21, C94.22, C94.30, C94.31, C94.80, C94.81, D45).

Effective for claims with dates of service on and after January 1, 2008, contractors shall deny non-ESRD ESA services for HCPCS J0881 or J0885 billed with modifier EC (ESA, anemia, non-chemo/radio) for:

- any anemia in cancer or cancer treatment patients due to bone marrow fibrosis,
- anemia of cancer not related to cancer treatment,
- prophylactic use to prevent chemotherapy-induced anemia,
- prophylactic use to reduce tumor hypoxia,
- patients with erythropoietin-type resistance due to neutralizing antibodies; and
- anemia due to cancer treatment if patients have uncontrolled hypertension.

Effective for claims with dates of service on and after January 1, 2008, non-ESRD ESA services for HCPCS J0881 or J0885 billed with modifier EB (ESA, anemia, radio-induced), shall be denied.

Effective for claims with dates of service on and after January 1, 2008, contractors shall deny non-ESRD ESA services for HCPCS J0881 or J0885 billed with modifier EA (ESA, anemia, chemo-induced) for anemia secondary to myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia when a hemoglobin 10.0g/dL or greater or hematocrit 30.0% or greater is reported.

NOTE: ESA treatment duration for each course of chemotherapy includes the 8 weeks following the final dose of myelosuppressive chemotherapy in a chemotherapy regime.

Effective for claims with dates of service on and after January 1, 2008, Medicare contractors shall have discretion to establish local coverage policies for those indications not included in NCD 110.21.

Denials of claims for ESAs are based on reasonable and necessary determinations established by NCD 110.21. A provider may have the beneficiary sign an Advanced Beneficiary Notice, making the beneficiary liable for services not deemed reasonable and necessary and thus not covered by Medicare.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: PR or CO

CARC: 50

RARC: N/A

MSN: 15.20

Medicare contractors have the discretion to conduct medical review of claims and reverse the automated adjudication if the medical review results in a determination of clinical necessity.

100.2.1 - CAP Required Modifiers
(Rev. 3721, Issued: 02-24-17, Effective: 05-25-17, Implementation: 05-25-17)

The A/B MAC (B) shall identify physicians who have elected CAP and will no longer pay the physician for drugs under the ASP system that were obtained through CAP. A/B MACs (B) shall continue to pay physicians for the administration of CAP drugs. Unless claims for the CAP drugs include the no-pay (J1), furnish as written (J3) modifier, or MSP (M2) modifier the claim will be denied.

 When physicians submit a claim for a drug they have provided under the CAP without the J1, J3, or MSP modifiers, *the contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.*
Group Code: CO
CARC: 96
RARC: N348
MSN: 7.7

A/B MACs (B) shall treat as unprocessable CAP claims with the following invalid modifier combinations on CAP claims:

J1 + J3 - invalid
J2 without a J1 - invalid

J2 + J3 - invalid

A/B MACs (B) shall treat as unprocessable claims received with invalid modifier combinations.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.
Group Code: CO
CARC: 16
RARC: N519
MSN: N/A

100.2.3 - Submitting the Prescription Order Numbers and No Pay Modifiers
(Rev. 3721, Issued: 02-24-17, Effective: 05-25-17, Implementation: 05-25-17)

On paper claims the prescription numbers must be entered in Item 19. On electronic claims the prescription number must be entered at the line level in the ASC X12 837 professional claim format, LOOP 2410 REF02 (REF01=XZ) of the 5010 version. As the Implementation Guide requires the entry of the National Drug Code (NDC) number in the LIN segment in order to enter the prescription number, the NDC will be required as well. The NDC must be submitted in LOOP 2410 LIN03 (LIN02=N4).

The prescription number will consist of the vendor identification (ID) number, the HCPCS code, and the vendor controlled prescription number. Each vendor controlled prescription number shall be a unique number and shall not consist of all zero's.

The standard system shall add the prescription number received on either paper or electronic claims to the claims screen and retain the information in history. A/B MACs (B) shall forward the prescription number on both paper and electronic claims to CWF.

For paper claims, A/B MACs (B) shall return as unprocessable paper claims submitted with the J1 modifier, but no prescription number.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.
Group Code: CO
CARC: 16
RARC: N388
MSN: N/A

The standard system shall create a pre-pass edit to reject claims from physicians or practitioners submitted with a no-pay modifier on a line, but without a prescription number on that same line.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.
Group Code: CO
CARC: 16
RARC: N388
MSN: N/A

100.2.3.1 - Further Editing on the Prescription Order Number
(Rev. 3721, Issued: 02-24-17, Effective: 05-25-17, Implementation: 05-25-17)

Prescription order numbers submitted with inappropriate spaces inserted disrupt the matching process between the physician/provider claims and the vendor claims. Effective for claims processed on or after July 7, 2008, contractors shall implement edits to treat these claims as unprocessable.

Prescription order numbers submitted with less than 10 characters on CAP claims will also be treated as unprocessable. For either of the two prior situations, *the contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.*
Group Code: CO
CARC: 16
RARC: N388
MSN: N/A

In addition, CAP physicians/providers and CAP vendors may not submit new claims (processed as entry code 1) with prescription order numbers that they have already submitted on previously adjudicated claims, even if the prior claims have been denied. The CAP physicians/providers and CAP vendors must request an adjustment to the original claim (processed as entry code 5). Claims that have been returned as unprocessable may be accepted with the original prescription order number when resubmitted after being corrected.

CWF will create a new utilization error code that will be returned when it receives a claim that has a prescription order number on it that matches a prescription order number already on file from a different claim. This claim could be from the same physician/provider/supplier or a different physician/provider/supplier. CWF coding will differentiate between claims from the physicians/providers and claims from the CAP vendors. It will be acceptable to allow a claim with a duplicate prescription order number as long as one claim is from a physician/provider and the other claim is from the vendor. This will allow the prescription order number matching process to continue.

Contractors shall treat as unprocessable the entire claim when a claim receives the new CWF utilization error code. Contractors shall not allow appeals rights on claims treated as unprocessable in response to the new error code.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO

CARC: 18

RARC: N389, M16 and N185

MSN: N/A

100.2.4 - CAP Claims Submitted With Only the No Pay Line
(Rev. 3721, Issued: 02-24-17, Effective: 05-25-17, Implementation: 05-25-17)

Physicians must submit their charges for the administration of CAP drugs and the no-pay lines on the same claim. A/B MACs (B) shall treat as unprocessable claims received that only have services submitted with the no-pay modifier.

100.2.8 - Claims Submitted for Only Drugs Listed on the Approved CAP Vendor's Drug List
(Rev. 3721, Issued: 02-24-17, Effective: 05-25-17, Implementation: 05-25-17)

The A/B MAC (B) shall edit to verify that the no-pay lines (lines with the CAP drug HCPCS code and the J1modifier) that the participating CAP physician has billed is for a drug included in the CAP and is from the particular CAP vendor they have chosen to receive drugs from.

If the A/B MAC (B) determines that the physician has billed no-pay lines along with the codes for the payment of the administration for drug HCPCS code(s) that are not provided by the approved CAP vendor that the physician had selected, it shall return as unprocessable those no-pay lines along with the lines for the codes for the payment of the administration for these drugs.

100.4.1 - Creation of Internal Vendor Provider Files
(Rev. 3721, Issued: 02-24-17, Effective: 05-25-17, Implementation: 05-25-17)

The designated A/B MAC (B) shall create an internal provider file for each vendor which includes the names, addresses, and UPINs, (NPI when effective), of those physicians who have elected that vendor.

The designated A/B MAC (B) shall edit incoming vendor claims to verify that the UPIN number on the claim for the ordering physician is one of the UPINs on the provider file for that vendor. The designated A/B MAC (B) shall treat the claim as unprocessable when it receives claims from vendors with ordering physician UPINs that do not match a physician UPIN on the provider file.

100.4.2 - Submission of Paper Claims by Vendors
(Rev. 3721, Issued: 02-24-17, Effective: 05-25-17, Implementation: 05-25-17)

The designated A/B MAC (B) shall treat as unprocessable paper claims submitted by vendors and *the contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three*

Group Code: CO
CARC: 96
RARC: M117
MSN: N/A

100.4.3 - Submission of Claims from Vendors With the J1 No Pay Modifier
(Rev. 3721, Issued: 02-24-17, Effective: 05-25-17, Implementation: 05-25-17)

The designated A/B MAC (B) shall treat as unprocessable claims submitted by vendors with a no-pay modifier, *the contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two*
Group Code: CO
CARC: 16
RARC: N265
MSN: 9.7 and 17.11

100.4.4 - Submission of Claims from Vendors Without a Provider Primary Identifier for the Ordering Physician
(Rev. 3721, Issued: 02-24-17, Effective: 05-25-17, Implementation: 05-25-17)

The designated A/B MACs (B) shall edit to determine if a UPIN, (or NPI when effective), of the ordering physician has been entered on the claim. If the UPIN, (or NPI when effective), has not been entered on the claim, the designated A/B MAC (B) shall treat the claim as unprocessable.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two
Group Code: CO
CARC: 206
RARC: N265
MSN: N/A

100.5.1 - Denials Due to Medical Necessity
(Rev. 3721, Issued: 02-24-17, Effective: 05-25-17, Implementation: 05-25-17)

If the lines are not approved due to medical necessity, *the contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.*
Group Code: CO
CARC: 50
RARC: N661
MSN:16.48

100.5.2 - Denials For Reasons Other Than Medical Necessity
(Rev. 3721, Issued: 02-24-17, Effective: 05-25-17, Implementation: 05-25-17)

If the designated A/B MAC (B) denies the lines due to other reason, *the contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.*

Group Code: CO

CARC: 96

RARC: RARC most descriptive of 'other' denial reason. CARC 96 requires an accompanying RARC.

MSN: 16.10

100.5.6 - Creation of a Weekly Report for Claims That Have Pended More Than 90 Days and Subsequent Action
(Rev. 3721, Issued: 02-24-17, Effective: 05-25-17, Implementation: 05-25-17)

The shared system shall create a weekly report for the designated A/B MAC (B) providing information on claims that have pended for more than 90 days. The designated A/B MAC (B) shall review the weekly report to identify and deny claim lines for which the 90 day time period has expired. Before denying the claim lines, the designated A/B MAC (B) shall determine if the physician claim had been submitted as a paper claim. If there is an approved physician paper claim for the beneficiary with the same HCPCS code and a date of service within 7 days of the date of service of the vendor drug claim posted at CWF and the details are not denied, the designated A/B MAC (B) shall pay the claim lines. If there is no claim on file that matches these criteria, or some details are denied, the designated A/B MAC (B) shall deny the corresponding claim lines.
The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.
Group Code: CO
CARC: 107
RARC: N/A
MSN: 21.21

100.8.3.1 - Editing for CAP NOC Drugs
(Rev. 3721, Issued: 02-24-17, Effective: 05-25-17, Implementation: 05-25-17)

Should the A/B MAC (B) receive a CAP NOC code, but the description does not match a CAP NOC drug on the approved list, *the contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.*
Group Code: CO
CARC: 16
RARC: N350
MSN: N/A

Should a non-CAP physician submit the CAP NOC code, *the contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.*
Group Code: CO
CARC: 16
RARC: N56
MSN: N/A

Should a CAP physician submit a J NOC code with a description of a CAP approved NOC drug, *the contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.*
Group Code: CO
CARC: 16
RARC: N56
MSN: N/A

Medicare Claims Processing Manual
Chapter 23 - Fee Schedule Administration and Coding Requirements

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20.9 - Correct Coding Initiative (CCI)
(Rev. 3721, Issued: 02-24-17, Effective: 05-25-17, Implementation: 05-25-17)

The CMS developed the Correct Coding Initiative (CCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. An overview of the CCI can be found on CMS Web site, https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/.

The CMS will e-mail an updated version of the **National Correct Coding Initiative Coding Policy Manual for Medicare Services** (Coding Policy Manual) to the ROs for distribution to the A/B MACs (B). The Coding Policy Manual should be utilized by A/B MACs (B) as a general reference tool that explains the rationale for CCI edits. A/B MACs (B) implemented CCI edits within their claim processing systems for dates of service on or after January 1, 1996.

The CCI edits are incorporated within the outpatient code editor (OCE).

The purpose of the CCI edits is to ensure the most comprehensive groups of codes are billed rather than the component parts. Additionally, CCI edits check for mutually exclusive code pairs. These edits were implemented to ensure that only appropriate codes are grouped and priced. The unit-of-service edits determine the maximum allowed number of services for each HCPCS code.

The official method for providers to receive the CCI edits is through National Technical Information Service (NTIS) Department of Commerce. The CMS has designated NTIS as the sole distributor of the CCI edits. The narrative introduction of the NTIS product is considered public domain and may be freely reproduced. However, the specific CPT code combinations may not be reproduced. However, neither the narrative introduction nor the narrative portion of each chapter is intended to supersede any current Medicare policy. Anyone wishing to receive the CCI edits must purchase them through NTIS.

To purchase the CCI edits, call the National Technical Information Service:

- To receive the information by fax, call (703) 605-6880.
- To order subscriptions, call (703) 605-6060 or (800) 363-2068.

Ordering and product information are also available via the World Wide Web at www.ntis.gov/product/correct-coding.htm

The following CCI instructions also apply to claims for Ambulatory Surgical Center (ASC) Facilities services. However, A/B MACs (B) do not pay an ASC facility fee for an approved code under CCI unless that code is on the list of Medicare-covered ASC procedures.

Standard language was developed for use in correspondence concerning questions related to specific code combinations or reductions in payment due to specific codes billed. The standard language and examples of edits are found in the Medicare Contractor Beneficiary and Provider Communications Manual, Chapter .1

For assigned and unassigned claims submitted to A/B MACs (B) for CCI editing on the same claim, the following reflects the remittance advice messages and associated codes that will appear when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario 3.

20.9.1.1 - Instructions for Codes With Modifiers (A/B MACs (B) Only)
(Rev. 3721, Issued: 02-24-17, Effective: 05-25-17, Implementation: 05-25-17)

A. General

A/B MACs (B) subject all line items with identical modifiers to the CCI edit.

All line items with identical modifiers must be subjected to the CCI edit. Line items with the modifiers listed below are NOT subject to the CCI edit. However, they are subject to additional edits based on the specific use of the modifier as defined in other instructions issued by CMS.

E1 - E4	FA	F1 - F9	TA	T1 - T9	LT	RT
-25	-58	-59	-78	-79	LC	LD
RC	-91					

B. Modifier "-59"

Definition - The "-59" modifier is used to indicate a distinct procedural service. The physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. This may represent a different session or patient encounter, different procedure or surgery, different site, or organ system, separate incision/excision, or separate injury (or area of injury in extensive injuries).

Rationale - Multiple services provided to a patient on one day by the same provider may appear to be incorrectly coded, when in fact the services may have been performed as reported. Because these circumstances cannot be easily identified, a modifier was established to permit claims of such a nature to bypass correct coding edits. The addition of this modifier to a procedure code indicates that the procedure represents a distinct procedure or service from others billed on the same date of service. In other words, this may represent a different session, different surgery, different anatomical site or organ system, separate incision/excision, different agent, different lesion, or different injury or area of injury (in extensive injuries).

Instruction - The secondary, additional, or lesser procedure(s) or service(s) must be identified by adding the modifier "-59".

Following are examples of appropriate use of the "-59" modifier:

EXAMPLE 1: CPT codes describing chemotherapy administration include codes for the administration of chemotherapeutic agents by multiple routes, the most common being the intravenous route. For a given agent, only one intravenous route (push or infusion) is appropriate at a given session. It is recognized that frequently combination chemotherapy is provided by different routes at the same session. When this is the case, using the CPT codes 96408, 96410, and 96414, the "-59" modifier (different substance) should be attached to the lesser valued technique indicating that separate agents were administered by different techniques.

EXAMPLE 2: When a recurrent incisional or ventral hernia requires repair, the appropriate recurrent incisional or ventral hernia repair code is billed. A code for initial incisional hernia repair is not billed in addition to the recurrent incisional or ventral hernia repair unless a medically necessary initial incisional hernia repair is performed at a different site. In this case, the "-59" modifier should be attached to the initial incisional hernia repair code.

Modifier "-59" may not be used with the following codes:

77427	Radiation treatment management, five treatments
99201 - 99499	Evaluation and management services

When a provider submits a claim for any of the codes specified above with the "-59" modifier, the A/B MAC (B) must process the claim as if the modifier were not present. In addition to those messages specified in §20.9.A above, A/B MACs (B) *shall convey additional messaging.*

The following reflects the remittance advice messages and associated codes that will appear when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario 2.

Group Code: CO
CARC: 4
RARC: N/A
MSN: See §20.9.A above

No additional message should be conveyed on the beneficiary's MSN.

C. Modifier "-91"

Definition - The "-91" modifier is used to indicate a repeat laboratory procedural service on the same day to obtain subsequent reportable test values. The physician may need to indicate that a lab procedure or service was distinct or separate from other lab services performed on the same day. This may indicate that a repeat

clinical diagnostic laboratory test was distinct or separate from a lab panel or other lab services performed on the same day, and was performed to obtain subsequent reportable test values.

Rationale - Multiple laboratory services provided to a patient on one day by the same provider may appear to be incorrectly coded, when in fact the services may have been performed as reported. Because these circumstances cannot be easily identified, a modifier "-91" was established to permit claims of such a nature to bypass correct coding edits. The addition of this modifier to a laboratory procedure code indicates a repeat test or procedure on the same day.

Instruction - The additional or repeat laboratory procedure(s) or service(s) must be identified by adding the modifier "-91".

EXAMPLE 1:   When cytopathology codes are billed, the appropriate CPT code to bill is that which describes, to the highest level of specificity, what services were rendered. Accordingly, for a given specimen, only one code from a family of progressive codes (subsequent codes include services described in the previous CPT code, e.g., 88104-88107, 88160-88162) is to be billed. If multiple services on different specimens are billed, the "-91" modifier should be used to indicate that different levels of service were provided for different specimens. This should be reflected in the cytopathologic reports.

D. Professional Component Modifier

Modifier 26 is used when reporting the physician component of a service separately. If this modifier is used with a Column II code that is reported with a Column I code, A/B MACs (B) deny the Column II code with the modifier.

E. Coding for Noncovered Services and Services Not Reasonable and Necessary

Effective January 1, 2002, new modifiers were developed to allow practitioners and suppliers to bill Medicare for items and services that are statutorily non-covered or do not meet the definition of a Medicare benefit and items and services not considered reasonable and necessary by Medicare. The following three codes and one modifier were therefore deemed obsolete and were discontinued.

     A9160 - Non-covered service by podiatrist
     A9170 - Non-covered service by chiropractor
     A9190 - Personal comfort item, (non-covered by Medicare statute)
     GX - Service not covered by Medicare

1. Definitions of the GA, GY, and GZ Modifiers

The modifiers are defined below:

    GA - Waiver of liability statement on file.
    GY - Item or service statutorily excluded or does not meet the definition of any Medicare benefit.
    GZ - Item or service expected to be denied as not reasonable and necessary.

2. Use of the GA, GY, and GZ Modifiers for Services Billed to A/B MACs (B)

The GY modifier must be used when physicians, practitioners, or suppliers want to indicate that the item or service is statutorily non-covered or is not a Medicare benefit.

The GZ modifier must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they have not had an Advance Beneficiary Notification (ABN) signed by the beneficiary.

The GA modifier must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they do have on file an ABN signed by the beneficiary. (See https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/abn_booklet_icn006266.pdf for additional information on use of the GA modifier and ABNs.)

The GY and GZ modifiers should be used with the specific, appropriate HCPCS code when one is available. In cases where there is no specific procedure code to describe services, a "not otherwise classified code" (NOC) must be used with either the GY or GZ modifier.

3. Use of the GA, GY, and GZ Modifiers for Items and Supplies Billed to DME MACs

The GY modifier must be used when suppliers want to indicate that the item or supply is statutorily non-covered or is not a Medicare benefit.

The GZ modifier must be used when suppliers want to indicate that they expect that Medicare will deny an item or supply as not reasonable and necessary and they have not had an Advance Beneficiary Notification (ABN) signed by the beneficiary.

The GA modifier must be used when suppliers want to indicate that they expect that Medicare will deny an item or supply as not reasonable and necessary and they do have on file an ABN signed by the beneficiary.

The GY and GZ modifiers should be used with the specific, appropriate HCPCS code when one is available. In cases where there is no specific procedure code to describe items or supplies, an NOC must be used with either the GY or GZ modifiers.

4. Use of the A9270

Effective January 1, 2002, the A9270, Noncovered item or service, under no circumstances will be accepted for services or items billed to A/B MACs (B). However, in cases where there is no specific procedure code for an item or supply and no appropriate NOC code available, the A9270 must continue to be used by suppliers to bill DME MACs for statutorily non-covered items and items that do not meet the definition of a Medicare benefit.

5. Claims Processing Instructions

At A/B MAC (B) and DME MAC discretion, claims submitted using the GY modifier may be auto-denied. If the GZ and GA modifiers are submitted for the same item or service, treat the item or service as having an invalid modifier and therefore unprocessable.

F. GZ Modifier

Effective for dates of service on and after July 1, 2011, A/B MACs (B) shall automatically deny claim line(s) items submitted with a GZ modifier. A/B MACs (B) shall not perform complex medical review on claim line(s) items submitted with a GZ modifier. All MACs shall make all language published in educational outreach materials, articles, and on their Web sites, consistent to state all claim line(s) items submitted with a GZ modifier shall be denied automatically and will not be subject to complex medical review.

The following reflects the remittance advice messages and associated codes that will appear when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario 3.

Group Code: CO
CARC: 50
RARC: N/A
MSN: 8.81