CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1453	**Date: FEBRUARY 22, 2008**
	Change Request 5855

This CR is being re-communicated to correct the July 1, 2008 date found on the transmittal page and in the Internet Only Manual Attachment, Pub. 100-04, Chapter 17, section 100.2.3.1. This date is now correctly revised to July 7, 2008. All other material remains the same.

SUBJECT: Systems Changes for Prescription Order Numbers for the Competitive Acquisition Program (CAP) for Part B Drugs and Biologicals

I. SUMMARY OF CHANGES: For claims processed on or after July 7, 2008, edits will be implemented to treat as unprocessable CAP claims received with inappropriate spaces in prescription order numbers as well as claims with prescription order numbers with less than 10 characters. In addition, a new CWF utilization error code will be developed so that contractors may treat as unprocessable claims submitted with duplicate prescription order numbers.

New / Revised Material
Effective Date: July 7, 2008
Implementation Date: July 7, 2008

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	17/100.2.3/Submitting the Prescription Order Numbers and No Pay Modifiers
N	17/100.2.3.1/Further Editing on the Prescription Order Number
R	1/80.3.2.1.3/Carrier Specific Requirements for Certain Specialties/Services

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: 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 Requirement
Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment – Business Requirements

Pub. 100-04	Transmittal: 1453	Date: February 22, 2008	Change Request: 5855

This CR is being re-communicated to correct the July 1, 2008 date found on the transmittal page and in the Internet Only Manual Attachment, Pub. 100-04, Chapter 17, section 100.2.3.1. This date is now correctly revised to July 7, 2008. All other material remains the same.

SUBJECT: Systems Changes for Prescription Order Numbers for the Competitive Acquisition Program (CAP) for Part B Drugs and Biologicals

Effective Date: For claims processed on or after July 7, 2008

Implementation Date: July 7, 2008

I. GENERAL INFORMATION

A. Background: Some providers are submitting CAP claims with prescription order numbers with inappropriate spaces inserted thus disrupting the matching process with the vendor claims. Contractors shall be directed to treat these claims as unprocessable. Contractors shall also be directed to treat as unprocessable CAP claims received with prescription order numbers less than 10 characters.

CAP physicians/providers and CAP vendors will not be allowed to submit new claims (processed as an 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 which will be processed as an entry code 5 to the original claim. CWF will continue to overlay these adjustments (entry code 5) on the CAP Auxiliary (AUX) file. CWF shall also continue to return an Informational Unsolicited Response when the adjustment overlays the current record and the pay/process indicator have changed. 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 (entry code 1) that has a prescription order number on it that matches a prescription order number already on the CAP AUX file from a different claim. CWF coding will differentiate between claims from the physicians/providers and claims from the CAP vendor. 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.

B. Policy: This CR represents no change to CAP policy.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5855.1	Contractors shall treat as unprocessable the entire claim when a claim is received with CAP services and blank spaces are included within the prescription order number.	X			X			X			CAP Designated

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
											Carrier
5855.1.1	Contractors shall treat as unprocessable the entire claim when a claim is received with CAP services and prescription order numbers less than 10 characters.	X			X			X			CAP Designated Carrier
5855.1.2	Contractors shall return the following Remittance Advice Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Codes (RARCs) when claims are treated as unprocessable per BRs 5855.1 and/or 5855.1.1: CARC 16 – Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) RARC MA130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information. RARC N388 – Missing/incomplete/invalid prescription number.	X			X						CAP Designated Carrier
5855.1.3	Contractors shall also return the messages in 5855.1.2 when paper claims submitted with the J1 modifier, but without a prescription order number, are returned as unprocessable. NOTE: This BR revises the instructions in BR4064.3.2.2.3/CR 4064 and BR 4309.7/CR4309.	X			X						
5855.2	The contractor shall create a new utilization error code that shall be generated when a new physician/provider claim (entry code 1) is submitted with a prescription order number that duplicates one already on file. NOTE: The edit shall set regardless of whether both claims were submitted by the same physician/provider or by different physicians/providers.									X	
5855.2.1	The contractor shall return the same utilization error code created in BR 5855.2 when a new vendor claim (entry code 1) is submitted with a prescription order number that duplicates one already on file. NOTE: The edit shall set regardless of whether both claims were submitted by the same vendor or different vendors.									X	
5855.3	Contractors shall treat as unprocessable the entire claim when a claim receives the new CWF error code established in BR 5855.2.	X			X						CAP Designated Carrier
5855.3.1	Contractors shall not allow appeals rights on claims treated as unprocessable in response to the new error code.	X			X						CAP Designated Carrier
5855.3.2	The contractors shall return the following CARC and RARCs: CARC 18 – Duplicate claim/service.	X			X						CAP Designated

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	RARC MA130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information. RARC N389 – Duplicate prescription number submitted. RARC M16 – Please see our web site, mailings, or bulletins for more details covering this policy/procedure/decision. RARC N185 – **Alert:** Do not resubmit this claim/service.										Carrier

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5855.8	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/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 site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your 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						

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	

B. For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): leslie.trazzi@cms.hhs.gov

Post-Implementation Contact(s): leslie.trazzi@cms.hhs.gov

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Carriers (RHHIs)* use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*, use the following statement:

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.

80.3.2.1.3 – Carrier Specific Requirements for Certain Specialties/Services

(Rev. 1453: Issued: 02-22-08; Effective/Implementation Dates: 07-07-08)

Carriers must return the following claim as unprocessable to the provider of service/supplier:

a. For chiropractor claims:

1. If the x-ray date is not entered in item 19 for claims with dates of service prior to January 1, 2000. Entry of an x-ray date is not required for claims with dates of service on or after January 1, 2000.

2. If the initial date "actual" treatment occurred is not entered in item 14. (Remark code MA122 is used.)

b. For certified registered nurse anesthetist (CRNA) and anesthesia assistant (AA) claims, if the CRNA or AA is employed by a group (such as a hospital, physician, or ASC) and the group's name, address, ZIP code, and PIN number, until the NPI is required, is not entered in item 33 or if the NPI is not entered in item 33a.of the Form CMS-1500 (8/05) when the NPI is required or, until the NPI is required, if their personal PIN is not entered in item 24K of the Form CMS-1500 (12-90) or if the NPI is not entered into item 24J of the Form CMS-1500 (8/05) when the NPI is required. (Remark code MA112 is used.)

c. For durable medical, orthotic, and prosthetic claims, if the name, address, and ZIP code of the location where the order was accepted were not entered in item 32. (Remark code MA 114 is used.)

d. For physicians who maintain dialysis patients and receive a monthly capitation payment:

1. If the physician is a member of a professional corporation, similar group, or clinic, and, until the NPI is required, the attending physician's PIN is not entered in item 24K of the Form CMS-1500 (12-90) or if the NPI is not entered into item 24J of the Form CMS-1500 (8/05) when the NPI is required). (Remark code N290 is used.)

2. If the name, address, and ZIP code of the facility other than the patient's home or physician's office involved with the patient's maintenance of care and training is not entered in item 32. (Remark code MA114 is used.) Effective for claims received on or after April 1, 2004, the name, address, and ZIP code of the service location for all services other than those furnished in place of service home – 12 must be entered.

e. For routine foot care claims, if the date the patient was last seen and the attending physician's PIN (or NPI when required) is not present in item 19. (Remark code N324 or N253 is used.)

f. For immunosuppressive drug claims, if a referring/ordering physician, physician's assistant, nurse practitioner, clinical nurse specialist was used and their name is not present in items 17 or their UPIN (until the NPI is required) is not present in 17a. or if the NPI is not entered in item 17b. of the Form CMS-1500 (8/05) when the NPI is required. (Remark code N264 or N286 is used.)

g. For all laboratory services, if the services of a referring/ordering physician, physician's assistant, nurse practitioner, clinical nurse specialist are used and his or her name is not present in items 17 or their UPIN (until the NPI is required) is not present in 17a. or if the NPI is not entered in item 17b. of the Form CMS-1500 (8/05) when the NPI is required. (Remark code N264 or N286 is used.)

h. For laboratory services performed by a participating hospital-leased laboratory or independent laboratory in a hospital, clinic, laboratory, or facility other the patient's home or physician's office (including services to a patient in an institution), if the name, address, and ZIP code of the location where services were performed is not entered in item 32. (Remark code MA114 is used.) Effective for claims received on or after April 1, 2004, the name, address, and ZIP code of the service location for all services other than those furnished in place of service home – 12 must be entered.

i. For independent laboratory claims:

1. Involving EKG tracing and the procurement of specimen(s) from a patient at home or in an institution, if the claim does not contain a validation from the prescribing physician that any laboratory service(s) performed were conducted at home or in an institution by entering the appropriate annotation in item 19 (i.e., "Homebound"). (Remark code MA116 is used.)

2. If the name, address, and ZIP code where the test was performed is not entered in item 32, if the services were performed in a location other than the patient's home or physician's office. (Remark code MA114 is used.) Effective for claims received on or after April 1, 2004, the name, address, and ZIP code of the service location for all services other than those furnished in place of service home – 12 must be entered.

j. For mammography "diagnostic" and "screening" claims, if a qualified screening center does not accurately enter their 6-digit, FDA-approved certification number in item 32 when billing the technical or global component. (Remark code MA128 is used.)

k. For parenteral and enteral nutrition claims, if the services of an ordering/referring physician, physician assistant, nurse practitioner, clinical nurse specialist are used and their name is not present in item 17 or their UPIN (until the NPI is required) is not

present in item 17a. or if the NPI is not entered in item 17b.of the Form CMS-1500 (8/05) when the NPI is required). (Remark code N264 or N286 is used.)

l. For portable x-ray services claims, if the ordering physician, physician assistant, nurse practitioner, clinical nurse specialist's name, and/or UPIN (or NPI when required) is not entered in items 17 or their UPIN (until the NPI is required) is not entered in item 17a. or if the NPI is not entered in item 17b. of the Form CMS-1500 (8/05) when the NPI is required). (Remark code N264 or N286 is used.)

m. For radiology and pathology claims for hospital inpatients, if the referring/ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist's name, if appropriate, is not entered in items or 17 or their UPIN (until the NPI is required) is not entered in item 17a. or if the NPI is not entered in item 17b. of the Form CMS-1500 (8/05) when the NPI is required. (Remark code N264 or N286 is used.)

n. For outpatient physical or occupational therapy services provided by a qualified, independent physical, or occupational therapist, Medicare policy does not require the date last seen by a physician, or the UPIN or NPI, when required, of such physician. Medicare policy does not require identification of the ordering, referring or certifying physician on outpatient therapy claims, including speech-language pathology service claims. However, providers and suppliers are required to comply with applicable HIPAA ASC X12 837 claim completion requirements. See Pub. 100-04, chapter 5, §20 and Pub. 100-02, chapter 15, §§220 and 230 for therapy service policies. Deletion of this claim requirement for outpatient therapy services does not apply to the requirements for the date last seen and the UPIN or NPI, when required, of the ordering and supervising physician/nonphysician practitioner for therapy services provided incident to the services of a physician, because the incident to policies continue to require them.

1. If the UPIN (or NPI when required) of the attending physician is not present in item 19. (Remark code N253 is used.)

2. If the 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) date patient was last seen by the attending physician is not present in item 19. (Remark code N324 is used.)

o. For all laboratory work performed outside a physician's office, if the claim does not contain a name, address, and ZIP code, and PIN (until the NPI is required) where the laboratory services were performed in item 32 or if the NPI is not entered into item 32a. of the Form CMS-1500 (8/05) when the NPI is required), if the services were performed at a location other than the place of service home – 12. (Use Remark code MA114.)

p. For all physician office laboratory claims, if a 10-digit CLIA laboratory identification number is not present in item 23. This requirement applies to claims for services performed on or after January 1, 1998. (Remark code MA120 is used.)

q. For investigational devices billed in an FDA-approved clinical trial if an Investigational Device Exemption (IDE) number is not present in item 23, for dates of service through March 31, 2008. (Remark code MA50 is used.) With the use of new modifier Q0, effective for dates of service on and after April 1, 2008, contractors will no longer be able to distinguish an IDE claim from other investigational clinical services. Therefore this edit will no longer apply.

r. For physicians performing care plan oversight services if the 6-digit Medicare provider number of the home health agency (HHA) or hospice is not present in item 23. (Remark code MA49 is used.)

s. For Competitive Acquisition Program drug and biological claims, in accordance with the instructions found in the Medicare Claims Processing Manual, Chapter 17, *Section 100.2.1 – Section 100.9*.

Medicare Claims Processing Manual
Chapter 17 - Drugs and Biologicals

Table of Contents
(Rev. 1453, 02-22-08)

100.2.3 – Submitting the Prescription Order Numbers and No Pay Modifiers

(Rev. 1453: Issued: 02-22-08; Effective/Implementation Dates: 07-07-08)

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 ANSI X12 837P LOOP 2410 REF02 (REF01=XZ) of the 4010A1 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. Carriers shall forward the prescription number on both paper and electronic claims to CWF.

For paper claims, the carriers shall return as unprocessable paper claims submitted with the J1 modifier, but no prescription number. *The contractors shall return the following Remittance Advice Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Codes (RARCs):*

CARC 16 – Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

RARC MA130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

RARC N388 – Missing/incomplete/invalid prescription number.

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 carriers shall return the following message*s*:

RARC MA130 – Your claim contains incomplete or invalid information, and no appeals rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

RARC N388 – Missing/incomplete/invalid prescription number.

100.2.3.1 – Further Editing on the Prescription Order Number
(Rev. 1453: Issued: 02-22-08; Effective/Implementation Dates: 07-07-08)

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. The Contractors shall return the following Remittance Advice Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Codes (RARCs) for either of the two prior situations:

CARC 16 – Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

RARC MA130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

RARC N388 – Missing/incomplete/invalid prescription number.

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 Contractors shall return the following Remittance Advice Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Codes (RARCs):

CARC 18 – Duplicate claim/service.

RARC MA130 – Your claim contains incomplete and/or invalid information, and no appeals rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

RARC N389 – Duplicate prescription number submitted.

RARC M16 – Please see our web site, mailings, or bulletins for more details covering this policy/procedure/decision.

*RARC N185 – **Alert:** Do not resubmit this claim/service.*