



News Flash - Rejected Claims Reminder

Fee-for-Service Medicare claims can be rejected by Medicare contractors (carriers, intermediaries (FIs), and Medicare Administrative Contractors (MACs)) for a variety of reasons including: incorrect billing information, terminated provider, the beneficiary is not eligible for Medicare or the claim was sent to the wrong contractor. If a provider has questions about a claim rejected by an FI/carrier or MAC, the provider should contact the contractor directly. *It is never appropriate to direct the beneficiary who received the service billed on the claim to the 1-800-Medicare toll free line to resolve a claim rejection.*

MLN Matters Number: MM5727 **Revised**

Related Change Request (CR) #: 5727

Related CR Release Date: September 21, 2007

Effective Date: August 14, 2007

Related CR Transmittal #: R75NCD, R1340CP

Implementation Date: October 1, 2007

Lumbar Artificial Disc Replacement (LADR)

Note: This article was updated on September 20, 2012, to reflect current Web addresses. This article was also revised on September 20, 2012, to reflect current Web addresses. This article was also revised on September 24, 2007, to reflect that CMS issued a second transmittal for CR5727. The second transmittal, R1340CP, contained revisions to the "Medicare Claims Processing Manual" that reflect the same information contained in the original article.

Provider Types Affected

All physicians, hospitals, and providers who submit claims to Medicare contractors (Carriers, Medicare Administrative Contractors (A/B MACs), or Medicare Fiscal Intermediaries (FIs)) for LADR provided to Medicare beneficiaries

Provider Action Needed



STOP – Impact to You

This article is based on Change Request (CR) 5727 that summarizes a national coverage analysis for the reconsideration of the national coverage determination (NCD) for LADR.

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**CAUTION – What You Need to Know**

Effective for dates of service on or after August 14, 2007, LADR is NOT COVERED for Medicare beneficiaries over 60 years of age.

**GO – What You Need to Do**

Make certain your billing staffs are aware of this change and that you issue the appropriate liability notices to beneficiaries in advance of the procedure consistent with Chapter 30 of the *Medicare Claims Processing Manual* at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf> on the CMS website. Providers should make certain to issue the **Advanced Beneficiary Notice (ABN) and/or (as appropriate) the Hospital Issued Notice of Noncoverage (HINN)** to the beneficiary over the age of 60 years who chooses to have LADR.

Background

On November 28, 2006, the Centers for Medicare and Medicaid Services (CMS) initiated a national coverage analysis for the reconsideration of the NCD on LADR. The original NCD for LADR was focused on a specific lumbar artificial disc implant (Charite™) because it was the only one with FDA approval at that time. In the original decision memorandum for LADR, CMS stated that when another lumbar artificial disc received FDA approval CMS would reconsider the policy. Subsequently, another lumbar artificial disc, ProDisc®-L, received FDA approval, which initiated the reconsideration of the NCD on LADR. After reviewing the evidence, CMS is convinced that indications for the procedure of LADR exclude the over age 60 populations; therefore, the revised NCD addresses the procedure of LADR rather than LADR with a specific manufacture's implant.

Key Points

- For services performed on or after August 14, 2007, Medicare contractors will consider LADR a non-covered service for Medicare beneficiaries over 60 years of age as indicated in the "Medicare NCD Manual", section 150.10 (see the *Additional Information* section of this article for information on accessing the NCD manual section attached to CR5727). **Note: For Medicare beneficiaries 60 years of age and younger, there is no national coverage determination, leaving such determinations to continue to be made by local Medicare contractors.**

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- Medicare contractors will deny claims submitted with Category III Codes 22857 and 0163T for Medicare beneficiaries over 60 years of age, (i.e. **on or after a beneficiary's 61st birthday**).
- Medicare contractors will deny claims submitted with ICD-9-CM procedure code 84.65 for Medicare beneficiaries over 60 years of age.
- Where claims are denied:
 - Associated Medicare Summary Notices to beneficiaries will contain a message (21.24) indicating "This service is not covered for patients over age 60."
 - The associated remittance advice will reflect Claim Adjustment Reason Code 96 "Non-covered charge(s)" and remittance advice remark code N386 ("This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx> on the CMS website. If you do not have web access, you may contact the contractor to request a copy of the NCD."

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR5727) issued to your Medicare FI, carrier, or A/B MAC. CR5727 contains two transmittals, one for the NCD and one for the revised "Medicare Claims Processing Manual" instructions. These two transmittals may be viewed by going to <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R75NCD.pdf> and <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1340CP.pdf>, respectively, on the CMS website.

If you have questions, please contact your Medicare FI, carrier, or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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