CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1088	**Date: OCTOBER 27, 2006**
	Change Request 5332

Subject: Instructions for the Coordination of Medicare Secondary Payer (MSP) claims for the Competitive Acquisition Program (CAP)

I. SUMMARY OF CHANGES: CAP claims processing instructions for MSP claims and where a beneficiary's MSP status is incorrectly determined.

New / Revised Material
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

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	17/100.2.1 CAP Required Modifiers
N	17/100.2.10 MSP Situations Under CAP

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1088	Date: October 27, 2006	Change Request: 5332

SUBJECT: Instructions for the Coordination of Medicare Secondary Payer (MSP) claims for the Competitive Acquisition Program (CAP)

Effective Date: January 1, 2007

Implementation Date: January 2, 2007

I. GENERAL INFORMATION

A. Background: This CR provides additional details, information and instructions for 1) the implementation of the CAP as outlined in CRs 4064, 4306, 4309, 4404 and 5079, 2) the coordination of Medicare Secondary Payer (MSP) claims for the Competitive Acquisition Program (CAP). Note: the term "carrier" used in this document will be superseded by the term "MAC" during the ongoing contracting reform process.

B. Policy: Section 303 (d) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 established section 1847B of the Social Security Act requiring the implementation of a competitive acquisition program (CAP) for Medicare Part B drugs and biologicals not paid on a cost or prospective payment system basis. Beginning with drugs administered on or after July 1, 2006, physicians are given a choice between buying and billing these drugs for beneficiaries with Medicare as their primary insurer under the average sales price (ASP) system or obtaining these drugs from vendors selected through a competitive bidding process. Participating CAP physicians agree to obtain all drugs included in the CAP drug category for Medicare beneficiaries who do not have another primary insurer from the approved CAP vendor. However, Medicare statutes allow for limited exceptions to this requirement.

One such exception includes Medicare Secondary Payer (MSP) situations. Section 1862(b) establishes provisions for Medicare as a secondary payer that are codified in 42 CFR Part 411. Section 1862(b) (6) specifically instructs physicians and other suppliers to identify, from information obtained from the beneficiary, payers primary to Medicare and to bill such payers prior to billing Medicare. This change request instructs carriers to continue allowing CAP physicians to obtain physician administered drugs from entities approved by the primary plan and bill the primary payer outside the CAP vendor when Medicare beneficiaries have other insurance primary to Medicare.

1. Drugs Obtained Through the Approved CAP Vendor for Beneficiaries Where It is Later Learned that Medicare is Not Primary

As a rule, physicians shall follow the guidelines set forth by the primary insurer when obtaining drugs. Providers who elect into the CAP voluntarily agree to obtain CAP drugs for Medicare beneficiaries exclusively through an approved CAP vendor. However, there are certain situations where a beneficiary may be determined to be a Medicare beneficiary at the time a CAP drug is ordered through the approved CAP vendor, but after the drug is administered and billed, it is determined that another insurer is primary to Medicare. If a drug is obtained through the CAP vendor because of an incorrect determination that Medicare was the primary insurer at the time the drug was obtained, both the provider and the approved CAP vendor are required to bill the primary insurer first. Upon receipt of the primary insurer's payment, MSP claims should then be submitted by the physician to their local carrier for the administration service and by the approved CAP vendor to the CAP designated carrier for the drug. Providers are required to submit MSP claims even if they believe there is no outstanding balance due. Such claims must adhere to CAP guidelines and include the drug HCPCS code, the prescription number provided by the approved CAP vendor and an appropriate CAP no-pay modifier. Approved CAP vendor claims must also adhere to CAP requirements and include the assigned prescription number.

All participating CAP providers are to submit MSP claims for CAP related drug administration services where the drug was obtained from the approved CAP vendor. Failure to submit an MSP claim for the drug administration prevents the processing of the vendor's MSP claim by the CAP designated carrier.

2. Drugs Obtained Outside of the CAP for Beneficiaries with Medicare

In certain rare situations, participating CAP providers may mistakenly obtain drugs for Medicare beneficiaries outside of the CAP vendor because they had determined that the beneficiary had another insurer that was primary to Medicare. In order to make an appropriate payment for drugs administered under these unusual circumstances, we are allowing temporary use of the J3 modifier to bypass CAP edits and pay the participating CAP provider at the current ASP rate.

We have requested a modifier for use in this rare situation. Local carriers will be notified through the usual quarterly update process when a new modifier is available. At that time, the J3 modifier will no longer be accepted for this purpose.

As we expect the situations that require this modifier to be infrequent, local carriers have the ability to review claims with this modifier to monitor for proper use and educational opportunities.

3. MSP Claims For Drugs Present on the Provider's CAP Drug List

Currently, participating CAP provider claims are subjected to a comparison to the provider's chosen CAP drug list. When a drug that is on the CAP drug list appears on a participating CAP provider's claim, it must have an appropriate CAP no-pay modifier and a prescription number to continue processing. Claims that do not have this information are returned to the provider per business requirement 4064.2 (Transmittal 777). In order to prevent processing errors for legitimate MSP claims where the drug billed on the provider's claim is present on the selected CAP drug list, local carriers are to implement a SCF rule allowing an override of the CAP claims processing edits. This SCF rule will allow claims to be identified as MSP and not require the CAP modifiers or prescription number.

II. BUSINESS REQUIREMENTS

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5332.1	Local carriers shall instruct CAP participating providers to order drugs per the rules and guidelines established by the beneficiary's primary insurance and administer it to the beneficiary.	X			X							
5332.1.1	Local carriers shall pay all processed MSP claims per existing Medicare MSP guidelines.	X			X							
5332.2	In situations where the participating CAP provider and the approved CAP vendor determined that Medicare was the primary payer and ordered and administered the drugs through the CAP, but before Medicare paid the claim, learned that another payer	X			X							

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	was primary to Medicare, the approved CAP vendor and the participating CAP physician shall first bill the primary payer.											
5332.2.1	In this situation, local carriers shall instruct participating CAP providers within their jurisdiction to submit all MSP claims for drug administration services (even if they believe no balance is due).	X			X							
5332.2.2	Local carriers shall return all CAP MSP claims from participating CAP providers as unprocessable if the claim does not contain a prescription number and an applicable CAP no pay modifier.	X			X							
5332.2.3	Local carriers shall return the following message: RA Remark Code 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.	X			X							
5332.3	Local carriers shall instruct participating CAP providers to report the CAP MSP modifier on each MSP claim drug line when the participating CAP provider obtained a CAP drug outside of the CAP program because the provider determined that another insurer was primary to Medicare but when processed it was determined that Medicare was the primary.	X			X							
5332.3.1	Local carriers shall instruct participating CAP providers within their jurisdiction to use the "J3" modifier temporarily until a specific CAP MSP modifier is created.	X			X							
5332.3.2	Local carriers shall instruct participating CAP providers to use	X			X							

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	the CAP MSP modifier when it is issued through the quarterly update process. At such time, local carriers shall no longer accept the "J3" modifier for purposes of processing MSP claims submitted by participating CAP physicians.											
5332.3.3	Local carriers shall bypass CAP edits for the drug claim when the MSP modifier is present to allow payment to the physician under the ASP methodology.	X			X							
5332.3.4	Local carriers shall instruct participating CAP physicians to maintain documentation in the beneficiary's medical record to provide further information on why they determined that Medicare was secondary to another payer.	X			X							
5332.3.5	The local carrier may review this information upon request to the participating CAP physician.	X			X							
5332.4	Local carriers shall bypass any edits and/or audits which may include SCF maintenance on the drug detail line if there is a Medicare secondary claim for a drug that is on the CAP drug list selected by the provider. This may be completed by implementing an SCF rule where: 1. AD drug agreement ind = y 2. AD HCPCS are part of the drug agreement and there is a MSP allowed amount.	X			X							
5332.5	Local carriers shall deny claims when a primary Medicare claim is received and an MSP record exists in CWF.	X			X							
5332.6	If Medicare paid as primary and the CAP provider later learns that there is another primary payer to Medicare, the physician shall notify Medicare by contacting the Coordination of Benefits	X			X							

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	Contractor and provide them with the MSP information.											
5332.7	MSP recovery rules and procedures shall apply in situations where it is determined that Medicare mistakenly made a primary payment for a CAP drug.	X			X							

III. PROVIDER EDUCATION

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5332.8	A provider education article related to this instruction will be available at 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 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. 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							
5332.8.1	Contractors shall instruct providers regarding the information in this change request via the MLN Matters	X			X							

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	article and any other viable provider outreach that they deem necessary.											

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Cassandra Black at cassandra.black@cms.hhs.gov at 410-786-4545 or Rebecca Kane at rebecca.kane@cms.hhs.gov or 410- 786-1589 for CAP policy issues and Richard Mazur at richard.mazur@cms.hhs.gov or 410-786-1418 for MSP issues.

Post-Implementation Contact(s):

VI. FUNDING

A. *For TITLE XVIII Contractors*:
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. *For Medicare Administrative Contractors (MACs)*:

The contractor is hereby advised that this constitutes technical direction as defined in your contract. We do not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified 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.

100.2.1 - CAP Required Modifiers

(Rev. 1088, Issued: 10-27-06, Effective: 01-01-07, Implementation: 01-02-07)

The carrier 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. Carriers 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 modifier (to be released)* the claim will be treated as unprocessable.

Carriers shall return the following Medicare Summary Notice (MSN) messages and Remittance Advice (RA) messages when physicians submit a claim for a drug they have provided under the CAP without the J1, J3*, or MSP* modifiers:

MSN 7.7 – Your physician has elected to participate in the Competitive Acquisition Program for these drugs. Claims for these drugs must be billed by the appropriate drug vendor rather than your physician.

Spanish Version 7.7 - Su médico eligió participar en el Programa de Adquisición Competitiva para estas medicinas. Las reclamaciones para estas medicinas deben ser facturadas por el distribuidor de medicinas adecuado y no por su médico.

Claim Adjustment Reason Code 96 – Non-covered charges.

RA Remark Code N348 - You chose that this service/supply/drug would be rendered/supplied and billed by a different practitioner/supplier.

Carriers 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

Carriers shall treat as unprocessable claims received with invalid modifier combinations. Carriers shall return any appropriate Remittance Advice Reason Codes and the following Remark Code messages when claims are received with invalid modifier combinations:

Remark Code 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.

and

Remark Code MA78 – Missing/incomplete/invalid HCPCS modifier

100.2.10 – MSP Situations Under CAP

(Rev. 1088, Issued: 10-27-06, Effective: 01-01-07, Implementation: 01-02-07)

Drugs Obtained Through the CAP for Beneficiaries With Insurance Primary to Medicare
Providers who elect into the CAP voluntarily agree to obtain CAP drugs for Medicare beneficiaries exclusively through an approved CAP vendor. In situations where participating CAP providers obtain a drug from the CAP vendor for a beneficiary who is incorrectly determined to have Medicare as their

primary insurer, but the provider and the CAP vendor must first bill the appropriate primary insurer for the drug and the administration service.

Upon receipt of the primary insurer's payment, MSP claims should then be submitted by the physician to their local carrier for the administration service and by the approved CAP vendor to the CAP designated carrier for the drug. Providers are required to submit MSP claims even if they believe there is no outstanding balance due. Such claims must adhere to CAP guidelines and include the drug HCPCS code, the prescription number provided by the approved CAP vendor and an appropriate CAP no-pay modifier. Approved CAP vendor claims must also adhere to CAP requirements and include the assigned prescription number.

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