Medicare
Carriers Manual
Part 3 - Claims Process

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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CHANGE REQUEST 1562

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents, Chapter IV	4-1 – 4-2 (2 pp.)	4-1 – 4-2 (2 pp.)
4123 - 4130	4-38.3 – 4-38.5 (3 pp.)	4-38.3 (1 pp.)

CLARIFICATION/MANUALIZATION--*EFFECTIVE DATE: N/A*
IMPLEMENTATION DATE: N/A

Section 4123, Durable Medical Equipment Regional Carriers (DMERCS)--DMERCs, Mandatory Assignment for Drug Claims is being added to manualize Transmittals B-01-15, B-01-21, and B-01-41, which address §114 of BIPA, requiring mandatory assignment on drugs paid by Medicare.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

CHAPTER IV
CLAIMS REVIEW AND ADJUDICATION PROCEDURES

Line Review - Health Insurance Claim Form

Items and Services Having Special Review Considerations

Section

If the claim for an IDE is denied because the approval period has not begun or has expired, use the appropriate message:

"Medicare cannot pay for this investigational device because the approval period for the investigation device in the FDA clinical trial has not begun."

"Medicare cannot pay for this investigational device because the approval period for the investigational device in the FDA clinical trial has expired."

If an FDA-approved investigational device or service incident to such a device is denied because the implantation, removal or replacement is determined to be not medically necessary or reasonable, use the **appropriate message:**

Message 15.35, 15.28, 15.29 or 15.30.

Assigned or unassigned claims received containing the HCPCS code and the "QA" modifier but lacking the investigation device exemption number should be developed.

4123. DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS (DMERCS)— MANDATORY ASSIGNMENT FOR DRUG CLAIMS

Mandatory Assignment

Under §114 of the Benefits Improvement and Protection Act of 2000 (BIPA), suppliers including but not limited to pharmacies, must accept assignment on all claims for drugs and biologicals that they bill to the DMERCs. 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.

Suppliers must accept assignment on claims for drugs and biologicals furnished on or after February 1, 2001. This requirement applies to all claims for drugs and biologicals a supplier submits to a DMERC, regardless of whether or not the supplier has a valid National Supplier Clearinghouse (NSC) number.

Exception:

Mandatory assignment does not apply to Healthcare Common Procedure Coding System (HCPCS) code E0590, which represents the dispensing fee for nebulizer drugs.

Beneficiary-Submitted Claims

DMERCs must deny any claims a beneficiary submits for drugs and biologicals with dates of service on or after February 1, 2001. The DMERCs must notify beneficiaries that suppliers are now required to accept assignment on such claims and, therefore, beneficiaries may not submit claims for drugs and biologicals themselves. When denying beneficiary-submitted claims, 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 34.9 (English): "If you already paid the supplier/provider, the supplier/provider must refund any amount that exceeds the Medicare payment amount."

MSN 34.9 (Spanish): "Si usted ya pagó el suplidor/proveedor, el suplidor/proveedor debe devolver caulquier cantidad que exceda la cantidad del pago de Medicare."

If a beneficiary-submitted claim contains other items in addition to drugs or biologicals, the claims processing system must replicate the claim and process the non-drug or non-biological items.

If the DMERC has sufficient evidence to show that the beneficiary already paid the supplier on an unassigned claim, the DMERC may make payment directly to the beneficiary.

Supplier-Submitted Unassigned Claims

A. If a supplier submits an unassigned claim with a date of service on or after February 1, 2001, for a drug or biological, the DMERC must process the claim as though the supplier accepted assignment.

B. If a supplier submits an unassigned claim with a date of service on or after February 1, 2001, for a drug or biological, but that claim also contains codes for items that are not drugs or biologicals, the DMERC must split the claim. This will result in two claims in the claims processing system: an unassigned claim for items other than drugs and biologicals, and an assigned claim for drugs and biologicals furnished on or after February 1, 2001.

In both scenarios above, use the following remittance message:

Remark code N71: "Your unassigned claim for a drug or biological was processed as an assigned claim. The law requires that you must take assignment on all claims for drugs and biologicals."

In addition, if the DMERC has sufficient evidence to show that the beneficiary already paid for the drug or biological, the following remittance advice must also be used:

Remark code MA72: "The beneficiary overpaid you for these assigned services. You must issue the beneficiary a refund within 30 days for the difference between his/her payment to you and the total of the amount shown as patient responsibility and as paid to the beneficiary on this notice." (Use this remark code on the claim level when the incoming claim indicated that the patient had already paid for the billed services.)

Use the following MSN messages on all supplier submitted unassigned claims for drugs or biologicals:

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."

The Non-Licensed Pharmacy Initiative

Section 4119 requires that all suppliers who bill the DMERCs for drugs for use with DMEPOS must have a pharmacy license to dispense drugs. In situations when a supplier bills unassigned drugs and equipment, accessories, or supplies on the same claim, the DMERC local and standard systems must ensure that they apply non-licensed pharmacy equipment, accessory, and supply edits and denials before they split the claim.

List of Affected HCPCS Codes

The DMERCs must work together to create a list of HCPCS drug and biological codes which suppliers must bill on an assigned basis. This will enable the claims processing system to implement all necessary edits. Finally, the DMERCs must work together to create a list of drug and related equipment codes to which the non-licensed pharmacy edit would apply in this situation. For this second list, the DMERCs need only add drugs that are used with equipment, and the equipment and related supplies and accessories that are used with those drugs, as opposed to all drugs that are subjected to the licensure edit. The DMERCs must share both lists with the standard systems maintainer in order to ensure that claims are edited properly.

Mandatory assignment applies only to those drugs and biologicals "for which payment may be made," i.e., Medicare-covered drugs. Thus, DMERCs must not include on this list or to mandatory assignment edits any drugs for which a DMERC would never pay (e.g., no benefit category or not under DMERC jurisdiction), and, thus, are not subject to mandatory assignment by the DMERCs.

4125. EYE REFRACTIONS (ITEM 7C)

The carrier must exclude that part of the total charge made by the physician for services involving eye care that relate to the procedures performed to determine the refractive state of the eyes. It will be necessary for the carrier to undertake appropriate development, wherever necessary, to ascertain whether refractive procedures were performed and to establish the reasonable charge for these procedures.

EXAMPLE: A beneficiary complaining of failing vision and watering of the eyes was examined by an ophthalmologist. In the course of the diagnostic ophthalmological eye examination the physician performed procedures to determine the refractive state of the eyes. The physician's bill showed a single inclusive charge for the entire diagnostic examination. Apart from the refractive procedures, all of the other services furnished by the ophthalmologist to the beneficiary are covered. Since the physician did not show separate charge for the refractive procedures, the carrier must determine what portion of the physician's total charge represents the charge for the procedure performed to determine the refractive state of the eyes.

In other situations, the physician may indicate the charge for procedures to determine the refractive state of the eye by an itemization of the specific charge, or by a statement of a percentage or proportion of the total charge. These values, if stated, should be evaluated by the carrier under the guidelines stated in §5217.

4130. PORTABLE X-RAY SERVICES (ITEM 7C)

A. Supplier Bills.--Whether a supplier of portable x-ray services completes an SSA-l490 or furnishes an itemized bill, both the supplier and the physician who ordered the services must be shown. In addition, all bills for portable x-ray services involving the sheet must show the reason an x-ray was required. If any of the information is not submitted with the claim, the carrier should obtain it before making payment. Where it is found that the service is not within the scope of the portable x-ray benefit (see §2070.4) or was not ordered by a physician, no payment may be made.

Carriers should assure, before making payment, that services are not routine screening procedures or tests in connection with routine physical examinations.

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