Medicare Learning Network
MLN Matters
CMS
Information for Medicare Fee-for-Service Health Care Professionals

News Flash - Medicare is starting a new program to encourage physicians to adopt e-prescribing systems. Incentive payments will be available beginning in 2009 for physicians who meet the requirements of the program. The initiative is part of the Administration's broader efforts to accelerate the adoption of health IT and the establishment of a health care system based on value. Beginning in 2009, and during the next four years, Medicare will provide incentive payments to eligible professionals who are successful electronic prescribers. Eligible professionals will receive a 2 percent incentive payment in 2009 and 2010; a 1 percent incentive payment in 2011 and 2012; and a one half percent incentive payment in 2013. Beginning in 2012, eligible professionals who are not successful electronic prescribers will receive a reduction in payment. Eligible professionals may be exempted from the reduction in payment, on a case-by-case basis if it is determined that compliance with requirement for being a successful prescriber would result in significant hardship. To read more, see the entire HHS Fact Sheet at *http://www.hhs.gov/news/facts/eprescribing.html* on the CMS website.

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Related Change Request (CR) #: 6131
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Related CR Transmittal #: R1578CP
Implementation Date: January 5, 2009

Implementation of a New Claim Adjustment Reason Code (CARC) No.213. "Non-compliance with the physician self-referral prohibition legislation or payer policy"

Provider Types Affected

Physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FI), Medicare Administrative Contractors (A/B MAC), regional home health intermediaries (RHHI), or Durable Medical Equipment Medicare Administrative Contractors (DME MAC)) for services provided to Medicare beneficiaries.

What You Need to Know

CR 6131, from which this article is taken, instructs carriers, FIs, A/B MACs, RHHIs, and DME MACs (effective January 1, 2009) to use the new Claim

Adjustment Reason Code (CARC) #213 when denying claims based on non-compliance with the physician self-referral prohibition.

Make sure that your billing staffs are aware of this new CARC code.

Background

Unless an exception applies (as referenced below), Section 1877 of the Social Security Act (the Act), prohibits a physician from referring a Medicare patient for certain designated health services (DHS) to an entity with which the physician (or his/her immediate family member(s)) has a financial relationship. A "financial relationship" includes both ownership/investment interests and compensation arrangements (for example, contractual arrangements).

The following services are DHS:

- Clinical laboratory services;
- Radiology and certain other imaging services (including MRIs, CT scans and ultrasound);
- Radiation therapy services and supplies;
- Durable medical equipment and supplies;
- Orthotics, prosthetics, and prosthetic devices;
- Parenteral and enteral nutrients, equipment and supplies;
- Physical therapy, occupational therapy, speech-language pathology services;
- Outpatient prescription drugs;
- Home health services and supplies; and
- Inpatient and outpatient hospital services.

Section 1877 of the Act also prohibits the DHS entity from submitting to Medicare, the beneficiary, or any entity for DHS, claims that are furnished as a result of a prohibited referral.

Note: Violations of this statute are punishable by: 1) Denial of payment for all DHS claims; 2) Refunds of amounts collected for DHS claims; and 3) Civil money penalties for knowing violations of the prohibition.

Prior to the publication of the new CARC #213 ("Non-compliance with the physician self-referral prohibition legislation or payer policy"), there was no specific code to describe claims that are denied based on "Stark" (the physician self-referral statute at Section 1877 of the Act). Therefore, so that both the DHS providers and the industry will know that claims are being denied because of non-compliance with the physician self-referral prohibitions; CR 6131, from which this article is taken, instructs carriers, FIs, A/B MACs, RHHIs, and DME MACs to use the new CARC No. 213 (effective January 1, 2009) when denying claims based on non-compliance with the physician self-referral prohibition

Your Medicare contractors will use this code any time they deny a claim because a physician (or one or more of their immediate family members) has a financial interest in a DHS provider and fails to meet one of the exceptions referenced below.

Exceptions

Please note that the statute enumerates various exceptions, including exceptions for physician ownership or investment interest in hospitals and rural providers. You can read these exceptions in Section 1877 of the Social Security Act Sec. 1877 which you can find at *http://www.cms.hhs.gov/PhysicianSelfReferral/Downloads/section_1877.pdf* on the CMS Website; and in 42 C.F.R. Part 411, Subpart J.) (42 U.S.C. Section 1395nn).

Additional Information

You can find more information about CARC #213 by going to CR 6131, located at *http://www.cms.hhs.gov/Transmittals/downloads/R1578CP.pdf* on the Centers for Medicare & Medicaid Services (CMS) website. You will find the updated *Medicare Claims Processing Manual* Chapter 1 (General billing requirements), Section 180 (Denial of Claims Due to Violations of Physician Self-Referral Prohibition) as an attachment to that CR.

If you have any questions, please contact your carrier, FI, A/B MAC, RHHI, or DME MAC at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.