CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 777

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: DECEMBER 9, 2005

CHANGE REQUEST 4064

NOTE: *Transmittal 761, dated November 22, 2005, is rescinded and replaced with Transmittal 777, dated December 9, 2005. This CR has been adjusted to reflect the new implementation dates and language has been added to reflect CWF implementation in April 2006 and MCS implementation in July 2006. All other information remains the same.*

SUBJECT: Competitive Acquisition Program (CAP) for Part B Drugs

I. SUMMARY OF CHANGES: This CR provides instruction for carriers, the standard system, the Common Working File, and the National Claims History to implement the coding, testing, and implementation of CR 3668 by April 3, 2006. This CR reflects new target dates that have resulted from the delay in the CAP program. However, the action items have not changed.

NEW/REVISED MATERIAL :

EFFECTIVE DATE : July 1, 2006

IMPLEMENTATION DATE : July 3, 2006

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/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

One-Time Notification

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

Attachment – One Time Notification

Pub. 100-04	Transmittal: 777	Date: December 9, 2005	Change Request: 4064

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SUBJECT: Competitive Acquisition Program (CAP) for Part B Drugs

The CMS has suspended the bidding and delayed the CAP implementation to allow time to review more fully public comments to the CAP Interim Final with Comment (IFC) (CMS-1325-IFC) as well as to implement further clarifications to the bidding process before we proceed to accept bids from vendors. We anticipate publishing a final rule in late 2005; bids would then be due to CMS no earlier than 30 days following the publication of the final rule. After the vendors are announced, we will conduct an election period, during which physicians can voluntarily choose to participate in the CAP program and enroll with a particular vendor. At present, we expect that drugs will first be delivered through the CAP by July 2006.

This CR reflects new dates as a result of the program delay. It rescinds CR 4000, which, was for the coding, testing, and implementation phases of CR 3668. CR 4064 will now be implemented over the April 2006 and July 2006 releases with an effective date of July 1, 2006, analysis and design will be done in the April 2006 and July 2006 releases with an implementation of July 3, 2006. CWF will fully implement with the April 2006 release and MCS will fully implement with the July 2006 release.

The dates for the annual calendar year physician elections will be in a forthcoming Physician Election CR. Due to issuance of the interim final regulation on CAP, business requirements 3668.8.4 and 3668.9.2 have been revised as have some other business requirements based on comments received during the review process. Requirements 3668.9.1 and 3668.3.3.1 have been deleted. In addition, the Remittance Advice messages and modifiers that were referenced in CR 3668 have now been defined.

I. GENERAL INFORMATION

A. Background: Section 303 (d) of the Medicare Prescription Improvement and Modernization Act (MMA) of 2003 requires 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 will be given a choice between buying and billing these drugs under the average sales price (ASP) system, or obtaining these drugs from vendors selected in a competitive bidding process. (For purposes of the CAP, a physician includes individuals defined under 1861 (s) and other practitioners who are authorized to provide physician services under 1861(s) and who can, within their State's scope of practice, prescribe and order drugs covered under Medicare Part B .) The Secretary may exclude drugs from the CAP if competitive pricing will not result in significant savings, or is likely to have an adverse impact on access to such drugs. The statute gives CMS the authority to select drugs, or categories of drugs, that will be included in the program, to establish geographic competitive acquisition areas, and to phase in these elements as appropriate.

A competition will be held every three years to award contracts to approved CAP vendors that will supply drugs and biologicals for the program. A 3-year contract will be awarded to qualified approved CAP vendors in each geographic area who have and maintain: 1) Sufficient means to acquire and deliver competitively biddable drugs within the specified contract area; 2) Arrangements in effect for shipping at least 5 days each week for the competitively biddable drugs under the contract and means to ship drugs in emergency situations; 3) Quality, service, financial performance, and solvency standards; and 4) A grievance and appeals process for dispute resolution. A vendor's contract may be terminated during the contract period if they do not abide by the terms of their contract with CMS. CMS will establish a single payment amount for each of the competitively bid drugs and areas, for this three year cycle there will be one drug category and one geographic area. After CAP drug prices are determined and vendor contracts are awarded the information will be posted to a directory on the Medicare Web Site.

This CR shall be fully implemented by July 3, 2006. The VIPS shared system and associated carriers are waived from implementing this CR due to their upcoming transition to the MCS system. Carriers are required to implement this CR once they transition to MCS.

B. Policy: Medicare physicians will be given an opportunity to elect to participate in the CAP on an annual basis. (Both physicians and other practitioners who provide physician services that include the authority to prescribe and order Medicare Part B drugs are eligible to elect to participate in CAP.) Physicians or practitioners who elect to participate in CAP will continue to bill their local carrier for drug administration. The participating CAP physicians will receive all of their drugs from the approved CAP vendor for the drug categories they have selected, with only one exception. The exception will be for "furnish as written" situations where the participating CAP physician specifies that due to medical necessity the beneficiary must have a certain brand of a drug or a particular product defined by the product's National Drug Code. In those cases if the drug is not available from the approved CAP vendor, the participating CAP physician may buy the drug, administer it to the beneficiary, and bill Medicare using the ASP system. The local carrier will monitor drugs obtained using the "furnish as written" provision to ensure that the participating CAP physician is complying with Medicare payment rules.

The CAP will also allow a participating CAP physician to provide a drug to a Medicare beneficiary from his or her own stock and obtain the replacement drug from the approved CAP vendor when certain conditions are met. The local carrier will monitor drugs ordered under the replacement provision to ensure that the participating CAP physician is complying with Medicare payment rules.

Approved CAP vendors must qualify for enrollment in Medicare, and will be enrolled as a new provider specialty. The approved CAP vendor's claims for the drugs will be submitted to one designated Medicare carrier. The approved CAP vendor will bill the Medicare designated carrier for the drug and the beneficiary for any applicable coinsurance and deductible. Payment to the approved CAP vendor for the drug is conditioned on verification that the drug was administered to the Medicare beneficiary. Proof that the drug was administered shall be established by matching the participating CAP physician's claim for drug administration with the approved CAP vendor's claim for the drug in the Medicare claims processing system by means of a prescription number on both claims. When they are matched in the claims processing system, the approved CAP vendor will be paid in full. Until drug administration is verified, the approved CAP vendor may not bill the beneficiary and/or his third party insurance for any applicable coinsurance and deductible.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4064.1	By April 3, 2006, CMS will post on its Web site a list of the vendors that have been selected to participate in CAP, the categories of drugs they will be providing, and the geographic areas within which each vendor will operate. The election process for 2006 will end May 18, 2006. The election process will end each year 45 days after the list of vendors is posted on the CMS Web site.									CMS
4064.1.1.1	Carriers shall find the vendor names and identification numbers on the CMS Web site.			X			X			
4064.1.1.1.1	When carriers receive applications, they shall verify that the chosen vendor is valid per the CMS Web site. If an invalid vendor has been chosen, an educational contact shall be made to resolve the issue.			X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4064.1.1.2.1	By May 25, 2006, carriers shall create a table indicating which physicians have elected to participate in CAP, for which drugs, and with which vendors. The physician's name, the street address, city, state, zip code, and phone number of the practice address/shipping address on the MCS provider file (location where the drugs will be administered), PIN, UPIN (or NPI when effective), e-mail address (if available) shall be included by MCS in the October 2005 release. For group practices that elect to participate in CAP, the group PIN as well as the individual PINs and UPINs (NPI when effective) shall be included.						X			
4064.1.1.2.2	If the mailing/correspondence address (where the participating CAP physician can be contacted directly) is different from the practice/shipping address, the mailing/correspondence shall be included. If the group or individual practice has more than one practice location where drugs are administered, each practice address/shipping location where drugs will be administered shall also be included by the carriers.			X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4064.1.2.0	By May 25, 2006, carriers shall forward to the designated carrier a list of all the physicians and practitioners who have elected to participate in CAP and all the information listed in 4064.1.1.2 .1 The carriers shall manually add any additional practice/shipping addresses and the mailing/correspondence address to the spreadsheet provided to them by MCS before sending the information to the designated carrier. The carriers shall remove any members of a group practice who do not qualify to provide services under the CAP program.			X						Designated carrier
4064.1.2.0.1	Every year, the date that carriers shall forward to the designated carrier a list of all the physicians and practitioners who have elected to participate in CAP and all the information listed in 4064.1.1.2.1 shall be 7 days after the end of the CAP election period. Should that date fall on a weekend, it shall be extended to the following Monday.			X						Designated carrier
4064.1.2.0.2	For 2006, and until further notice, the designated carriers shall be Noridian. The designated carrier shall be the only carrier that will process CAP claims submitted by the drug vendors.			X						Designated carrier
4064.1.2.1	In order to simplify the transfer of information, prior to April 3, 2006, the carriers and the designated carrier shall determine a common format in which to send the information to the designated carrier. This format shall remain constant for subsequent years.			X						Designated carrier

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4064.1.3.1	By June 2, 2006, the designated carrier shall transmit information to each vendor on the physicians and practitioners who have elected that particular vendor. The designated carrier shall include the following information: The name, the street address, city, state, zip code, and phone number of each practice address/shipping address (location where the drugs will be administered), PIN, UPIN (or NPI when effective), e-mail address (if available) of the physician or practitioners who have elected to participate in CAP with that vendor and the drugs they have chosen. If the mailing/correspondence address (where the participating CAP physician can be contacted directly) is different from the practice/shipping address, the mailing/correspondence shall be included. If the group or individual practice has more than one practice location where drugs are administered, each practice address/shipping location where drugs will be administered shall also be included. For group practices that elect to participate in CAP, the group PIN as well as the individual PINs and UPINs (NPI when effective) shall be included.									Designated carrier

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4064.1.3.2	Each year the date the designated carrier shall transmit information to each vendor on the physicians and practitioners who have elected that particular vendor from 4064.1.3.1 shall be 7 days after the final date the carriers forward to the designated carrier the list of all the physicians or practitioners who have elected to participate in CAP. Should that date fall on a weekend, it shall be extended to the following Monday.									Designated carrier
4064.1.3.3	The designated carrier shall not send a vendor any information pertaining to other vendors.									Designated carrier
4064.2	Carriers shall flag the physicians and practitioners and deny claims for drugs for which physician and practitioners have elected to order under CAP unless the no-pay, restocking, or furnish as written modifier is included on the claim.			X			X			

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4064.2.1	For those claims denied in 4064.2, carriers shall return the following Medicare Summary Notice (MSN) messages and Remittance Advice (RA) messages: New 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. New RA Remark Code N348 - You chose that this service/supply/drug would be rendered/supplied and billed by a different practitioner/supplier.			X						
4064.3	Carriers shall pay for the administration of the drugs for which physician or practitioners have elected to receive under CAP.			X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4064.3.1.0.1	On both paper and electronic claims, the physician or practitioner shall submit the administration and/or E&M codes on separate lines and an additional no-pay service line for each prescription number. Each no-pay service line shall include a HCPCS drug code, the no-pay modifier. Contractors shall accept claims submitted with the new CAP no-pay modifier – J1 – Competitive Acquisition Program, no-pay submission for a prescription number, and a prescription number. On paper claims (Form 1500), the prescription numbers will be in Item 19. The no-pay service lines shall be submitted with the regular billed charge. Services received with the CAP no-pay modifier shall bypass the MSP Pay module.			X			X		X	
4064.3.1.0.2	Carriers, MCS, and CWF shall code their systems to accept services with the CAP no-pay modifier submitted with billed charges.			X			X		X	
4064.3.1.0.3	Carriers, MCS, and CWF shall transmit to CWF a pay/process indicator that will be established in the CWF documentation for services with the CAP no-pay modifier submitted with the billed charges.			X			X		X	
4064.3.1.0.4	No payment shall be made for these services (services with the CAP no-pay modifier).			X			X		X	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4064.3.1.1	In order to simplify CWF processing, on the claim lines with the drug codes, the CAP no-pay modifier needs to appear in the first modifier position. Should a claim be submitted with that modifier in other than the first position, the carriers shall sort the modifiers so that the CAP no-pay modifier always appears in the first position when the claim information is sent to CWF.			X						
4064.3.2.0	Carriers, the designated carrier, and CWF shall recognize the prescription number that will consist of the vendor identification (ID) number, the HCPCS code, and the vendor controlled prescription number.			X			X		X	Designated carrier
4064.3.2.0.1	CWF shall add a new field to the HUBC record at the line level to accommodate the prescription number. This number will consist of: Positions 1 – 4 = Vendor ID Number Positions 5 – 9 = HCPCS code Positions 10 – 30 = Vendor Controlled Prescription Number Each vendor controlled prescription number shall be a unique number and shall not consist of all zero's.								X	Designated carrier
4064.3.2.0.2	For electronic claims, carriers and the designated carrier shall send the prescription numbers to CWF. Until MCS can make changes for paper claims to accommodate the prescription number on the claim, the prescription number will not be sent to CWF for paper claims.			X			X		X	Designated carrier

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4064.3.2.1.1	The carrier shall receive the prescription number on the claim for the administration in Item 19 of the Form CMS-1500. The carrier shall accept all prescription numbers entered in Item 19.			X						
4064.3.2.1.2	The carrier shall receive the prescription number at the line level in the ANSI X12 837P LOOP 2410 REF02 (REF01=XZ). As the Implementation Guide requires the entry of the National Drug Code (NDC) in the LIN segment in order to enter the prescription number, the NDC will be required as well. The NDC will be submitted in LOOP 2410 LIN03 (LIN02=N4).			X						
4064.3.2.2.1	For electronic claims, MCS shall store and forward the prescription number(s) and not add them as part of the claim screens.						X			
4064.3.2.2.2	For paper claims, the carriers shall accept the prescription number(s) and shall manually create a claim comment and enter the prescription number submitted in Item 19 of Form CMS-1500.			X			X			
4064.3.2.2.3	For paper claims, the carriers shall return as unprocessable paper claims submitted with the J1 modifier, but no prescription number.			X						
4064.3.2.2.3.1	The 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						
4064.3.3	MCS 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.			X			X			

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4064.3.4	Physicians and practitioners shall be required to submit the administration and/or E&M services and the no-pay lines on the same claim. Carriers shall treat as unprocessable claims received that only have services submitted with the no-pay modifier.			X						
4064.3.4.1	Carriers shall return the following RA messages: Claim Adjustment Reason Code 16 – Claim/service lacks information, which is needed for adjudication. Additional information is supplied using the remittance codes whenever appropriate. Remark Code M67 – Missing/incomplete/invalid other procedure code(s).			X						
4064.3.5	Physicians and practitioners shall be required to submit only CAP related services on a claim, i.e., the administration or E&M services and the no-pay lines for the drugs. Services unrelated to CAP should be submitted on a separate claim. If a claim is received with additional services unrelated to the CAP drugs and their administration, carriers shall split the claim into CAP services and non-CAP services and continue to process.			X						
4064.4	CWF and MCS shall create a method to match the prescription numbers from the physician or practitioner claims to the prescription numbers on the vendor claims.						X		X	Designated Carrier

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4064.5	Under certain circumstances, physician or practitioners will be permitted to administer a drug they have on hand and go through the CAP program to restock it. Once the physician or practitioner orders and receives the restocking drug from the approved CAP vendor, the physician or practitioner will bill for his or her administration fee. He or she will also include no-pay lines on the claim for each of the drugs as usual. These lines will include the new restocking modifier, the no-pay modifier, the procedure code for the drug, and the prescription number as well as all other elements normally required. Carriers shall consider "restocking" drug claims for payment when the following requirements are met: a) The physician has elected to receive the drug under CAP; b) The physician has submitted the claim with the "restocking" modifier; c) The physician received the drug from the CAP vendor to replace a drug he or she used from pre-existing stock. d) The claim was submitted with the new "restocking" modifier J2 – Competitive Acquisition Program, (CAP) restocking of emergency drugs after emergency administration. By including the "restocking" modifier on the claim, the physician or practitioner is asserting that: a) The drug was required immediately; b) The need couldn't be anticipated; c) The vendor couldn't deliver in time; d) The drug was administered in an emergency situation; and			X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4064.5 (Cont.)	e) Documentation is being maintained on file to validate the information in items a to d, and will be made available to the carrier at their request.									
4064.5.1.1	Carriers shall consider "furnish as written" drug administration claims for payment outside of the CAP program when the new "furnish as written" modifier *J3 – Competitive Acquisition Program, (CAP) drug not available through CAP as written, reimbursed under average sales price methodology* is included. Carriers shall make adjustments as necessary to bypass the edit in 4064.2 when this modifier is submitted. By including the modifier on the claim, the physician or practitioner is asserting that: a) A specific drug product was medically necessary; b) The selected drug vendor could not provide that specific brand and/or NDC; and c) Documentation is being maintained on file to validate the information in a) and b) and will be made available to the carrier at their request.			X						
4064.5.1.2	Carriers shall not verify the assertions in 4064.5.1.1 on a pre-pay basis before allowing payment for the claim.			X						
4064.5.2	As part of their normal data analysis, carriers shall monitor these claims submitted with the "restocking" modifier or the "furnish as written" modifier for patterns of abuse and follow the Progressive Corrective Action (PCA) process described in the Program Integrity Manual, chapter 3.			X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4064.6.0	Carriers and/or program safeguard contractors shall apply all local coverage determination (LCD) policies and national coverage determination (NCD) policies to the administration, E&M, and no-pay drug code lines on the CAP claims.			X						Program Safeguard Contractors
4064.6.0.1	Should it be determined that an administration, E&M, or drug code service line does not meet the requirements of the LCD, the carrier shall follow current processes to determine how to adjudicate the related services.			X						Program Safeguard Contractors
4064.6.0.2	If appropriate, the carriers shall include messages on the MSN to indicate which LCD was applied which the designated carrier shall identify through contact with the local carrier.			X						Program Safeguard Contractors
4064.6.0.3	The carriers shall also apply all regular edits to the administration, E&M, and no-pay drug lines and send appropriate denial messages.			X						Program Safeguard Contractors
4064.6.1	The carrier shall send to CWF a pay/process indicator for each line of the claim, (including the administration code lines, the E&M code lines, and the drug code lines), to indicate whether it is approved, not-payable due to medical necessity, or not payable due to a reason other than medical necessity.			X					X	
4064.6.2	When CWF finds a prescription number that matches a prescription number on the claim, it shall notify the designated carrier. The designated carrier shall make payment for the drug lines that have a pay/process indicator of approved.						X		X	Designated carrier

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4064.6.3.0	Should carriers make adjustments to the physician or practitioner claims, they shall forward any changes in the pay/process indicators to CWF. .			X			X		X	Designated Carrier
4064.6.3.0.1	The CWF shall make any changes to the pay/process indicator as necessary to keep it current. CWF shall notify the designated carrier of any changes to the pay/process indicators so that they may respond accordingly.						X		X	Designated Carrier
4064.6.3.0.2	If it is determined on a post-pay basis that based on a change to the pay-process indicator the designated carrier has now made an overpayment, the designated carrier shall initiate an overpayment recovery action. If it is determined that they have made an underpayment, they shall also take appropriate action.									Designated Carrier
4064.6.3.1	Carriers and the designated carrier shall follow the instructions in the Program Integrity Manual, chapter 3 and the Medicare Financial Management Manual, chapter 3, for overpayment recovery.			X						Designated carrier
4064.7	The designated carrier shall follow normal procedures to enroll the Drug Vendors as provider specialty type, 95, Competitive Acquisition Program (CAP) for Part B drug vendors. Any necessary changes to the Medicare Claims Processing Manual to include the new specialty code will be forthcoming in a separate CR.								X	Designated carrier
4064.7.1	The designated carrier shall also assign a separate 4 position, alpha-numeric vendor identification number to be used in the prescription number and keep a master list of which numbers are assigned to which vendors.									Designated carrier

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4064.7.1.1	The designated carrier shall track the name, the address, zip code, and phone number of each practice location/shipping address (location where the drugs will be administered), PIN, UPIN, (or NPI when effective), and e-mail (if available) of the physicians and practitioners and physician groups and which vendors and which drugs they have chosen. In addition, the mailing/correspondence address (where the participating CAP physician can be contacted directly) for each physician shall also be tracked.									Designated carrier
4064.7.1.2	The designated carrier shall make the information required in 4064.7.1 and 4064.7.1.1 readily available to CMS upon request.									Designated carrier
4064.7.2	The designated carrier shall only process CAP claims from approved drug vendors submitted in a HIPAA-compliant standard electronic format 4010A1 version (or later). All vendor claims shall be processed by the designated carrier.									Designated carrier
4064.7.3	The designated carrier shall treat as unprocessable paper claims submitted by vendors.									Designated carrier
4064.7.3.1	The designated carrier shall return the following RA messages: Claim Adjustment Reason Code 96 – Non-covered charge(s). Remark Code M117 – Not covered unless submitted via electronic format.									Designated carrier
4064.7.4	The designated carrier shall treat as unprocessable claims submitted by vendors with a no-pay modifier.									Designated carrier

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4064.7.4.1	The designated carrier shall return the following RA messages: Claim Adjustment Reason Code 96 – Non-covered charge(s). 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.									Designated carrier
4064.7.5	The designated carrier shall reserve the right to solicit, at any time, medical information to support adjudication of the drug vendor's claim.									Designated carrier
4064.7.6	The CMS will provide a fee schedule for the payment of CAP drugs to the designated carrier and MCS. The fees will be provided in a file on the CMS mainframe at a later date. The file layout is attached.						X			Designated carrier
4064.8	The CWF shall create a method by which claim lines from physicians or practitioners with prescription numbers and no-pay modifiers and claim lines from vendors with prescription numbers can be matched. As the claims are coming from different entities, one claim will always be received before the other. CWF shall consider this when developing its matching methodology. The CWF shall develop a way to communicate between carriers when a matching claim is received to let them know the claim has been received and the status of the lines on the claim, i.e., approved, denied due to medical necessity, denied due to another reason.						X		X	Designated carrier

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4064.8.1	When the designated carrier receives notification from CWF that the matching physician or practitioner claim is on file, it shall pay the approved drug lines on the vendor claim. It shall deny any lines not approved.						X		X	Designated carrier
4064.8.2	If the lines are not approved due to medical necessity, the designated carrier shall return the following messages: Claim Adjustment Reason Code 50 – These are non-covered services because this is not deemed a "medical necessity" by the payer. MSN -16.48 – Medicare does not pay for this item or service for this condition.									Designated carrier
4064.8.3	If the designated carrier denies the lines due to other reason, it shall use the following messages: Claim Adjustment Reason Code 96 – Non-covered charge(s). MSN 16.10 – Medicare does not pay for this item or service.									Designated carrier
4064.8.4	If the designated carrier receives a claim from the vendor and CWF determines some or all of the lines on the claim do not have a match, the designated carrier shall pend the claim for 90 days.						X			Designated carrier
4064.8.4.1	However, prior to the end of the 90 day period, if at the vendor's request the designated carrier can determine that a matching paper physician or practitioner claim is on file per the criteria in 4064.9.1.1.1 for paper claims, the designated carrier shall allow payment of the approved services on the claim.						X			Designated carrier

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4064.8.4.2	The designated carrier may also recycle the claim back to CWF at their discretion to determine if a matching electronic claim has been received prior to the end of the 90 day period.						X			Designated carrier
4064.8.4.3	No interest shall be paid on the pending claim.						X			Designated carrier
4064.9	MCS shall create a weekly report for the designated carrier providing information on claims that have pended for more than 90 days.						X			Designated carrier
4064.9.1	The designated carrier shall review the weekly MCS report to identify and deny claim lines for which the 90 day time period has expired.									Designated carrier
4064.9.1.1	Before denying the claim lines, the designated carrier shall determine if the physician or practitioner claim had been submitted as a paper claim.									Designated carrier
4064.9.1.1.1	If there is an approved physician or practitioner paper claim for the beneficiary with the same HCPCS code and a date of service within 7 days of the date of service of the vendor drug claim posted at CWF and the details are not denied, the designated carrier shall pay the claim lines.									Designated carrier
4064.9.2	If there is no claim on file that matches these criteria, or some details are denied, the designated carrier shall deny the corresponding claim lines.									Designated carrier

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4064.9.2.1	The designated carrier shall return the following messages: MSN – 21.21 – This service was denied because Medicare only covers this service under certain circumstances. RA Claim Adjustment Reason Code - 107 – Claim/service denied because the related or qualifying service was not previously paid or identified on this claim.									Designated carrier
4064.10	The CWF and the designated carrier shall submit claims for full payment of drug claims to the Coordination of Benefits contractor (COBC) for crossover to trading partners, in accordance with the requirements specified in Transmittal 138 (CR 3218).								X	Designated carrier
4064.11	The CWF shall pass the prescription number to National Claims History to be stored there.								X	National Claims History
4064.11.1	The NCH shall create a place for the prescription number to be stored.									National Claims History

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4064.1	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn 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 Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.			X						Designated Carrier

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: July 1, 2006 **Implementation Date:** July 3, 2006 **Pre-Implementation Contact(s):** Lia Prela – Cecilia.Prela@cms.hhs.gov Leslie Trazzi –Leslie.Trazzi@cms.hhs.gov Bridgitte Davis – Bridgitte.Davis@cms.hhs.gov For Coordination of Benefits/Crossover Issues - Brian Pabst Brian.Pabst@cms.hhs.gov For MSP issues: Rick Mazur – Richard.Mazur@cms.hhs.gov For medical review issues: Dan Schwartz – Daniel.Schwartz@cms.hhs.gov **Post-Implementation Contact(s):** Appropriate regional office	**No additional funding will be provided by CMS; contractor activities shall be carried out within their FY 2006 operating budgets.**

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

Attachment

Attachment

COMPETITIVE ACQUISITION PROGRAM FEE SCHEDULE FILE RECORD DESCRIPTION

Field Name	Position	Length	Format	Description
HCPCS	1-5	5	Character	Healthcare Common Procedure Coding System
Filler	6-7	2		Space Filled
State	8-9	2	Character	Alpha Abbreviation
Filler	10-11	2		Space Filled
Current Year	12-15	4	Numeric	YYYY
Filler	16-17	2		Space Filled
Current Quarter	18	1	Numeric	Calendar Quarter – value 1-4
Filler	19-20	2		Space Filled
Fee	21-26	6	Numeric	Fee to Pay For Drug $$$$$$
Filler	27-80	62	Character	Space Filled

The CMS will upload the CAP Part B Drug file to the Direct Connect each calendar quarter. Approximately 6 weeks prior to the beginning of each calendar quarter (i.e., approximately 6 weeks prior to January 1, April 1, July 1, and October 1) an email will be sent out providing notification of the availability of the updated file. The updated file will be available in the early November for the January 1 release, early February for the March 1 release, early May for the July 1 release, and early August for the September 1 release.