



News Flash - The 2008 Physician Election Period for the Medicare Part B Drug Competitive Acquisition Program (CAP) will begin on October 1, 2007 and concludes on November 15, 2007. The CAP is a voluntary program that offers physicians the option to acquire many injectable and infused drugs they use in their practice from an approved CAP vendor, thus reducing the time they spend buying and billing for drugs. The 2008 CAP program will run from January 1 to December 31, 2008. Once a physician has elected to participate in CAP, they must obtain all drugs on the CAP drug list from the CAP drug vendor. Physicians can still continue to purchase and bill Medicare under the Average Sale Price (ASP) system for those drugs that are not provided by the physician's CAP vendor. Additional information about the CAP is available at http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp on the CMS website. Please note that completed and signed physician election forms should be returned by mail to your local carrier. Forms must be postmarked on or before November 15, 2007. DO NOT return forms to CMS offices.

MLN Matters Number: MM5606

Related Change Request (CR) #: 5606

Related CR Release Date: October 15, 2007

Effective Date: January 1, 2008

Related CR Transmittal #: R1353CP

Implementation Date: January 7, 2008

Application of Administrative Simplification Compliance Act (ASCA) Enforcement Review Decisions Made by Other Medicare Contractors to the Same Providers When Selected for ASCA Review by the Railroad Medicare Carrier, Elimination of References to Claim Status and COB Medicare HIPAA Contingency Plans and Changes to Reflect Transfer of Responsibility for Medigap Claims to the COBC Contractor

Provider Types Affected

Physicians, providers, and suppliers submitting claims to the Railroad Medicare carrier, and other Medicare carriers, Part A/B Medicare Administrative Contractors (A/B MACs), and/or DME Medicare Administrative Contractors (DME MACs) for services provided to both Railroad and non-Railroad Medicare beneficiaries.

Provider Action Needed

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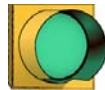
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**STOP – Impact to You**

This article is based on Change Request (CR) 5606, which implements a process to enable the application of the Administrative Simplification Compliance Act (ASCA) enforcement review decisions made by non-Railroad (non-RR) Medicare Contractors to the same providers when they bill the Railroad (RR) Medicare Carrier (RMC).

**CAUTION – What You Need to Know**

Due to distribution of RR retirees, many providers submit fewer than 10 claims a month to the RR Medicare Carrier (RMC), and these providers have been allowed to continue to submit paper claims to the RMC. The same providers may also treat non-RR Medicare beneficiaries and submit more than 10 claims a month to other Medicare contractors. ASCA electronic claim filing exceptions apply to Medicare overall, and do not differentiate based on contractors or between RR and non-RR contractors. By adding ASCA enforcement review decision information to the file sent from non-RR Medicare contractors to the RMC to share provider data, the RMC can apply decisions that providers are ineligible to submit paper claims to those same providers when they bill the RMC.

**GO – What You Need to Do**

See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

The Administrative Simplification Compliance Act (ASCA) requires that providers submit claims to Medicare electronically to be considered for payment, with a limited number of exceptions including an exception that allows providers that submit fewer than 120 claims per year (no more than 10 claims per month or 30 claims per quarter) to Medicare to continue to submit paper claims. See the *Medicare Claims Processing Manual*, Chapter 24, Sections 90-90.6 at <http://www.cms.hhs.gov/manuals/downloads/clm104c24.pdf>.

Due to the dispersion of railroad (RR) retirees in the United States, however, few physicians/practitioners/suppliers treat a large number of RR Medicare beneficiaries. As result, many of these providers submit fewer than 10 claims a month to the RR Medicare Carrier (RMC), and they have been allowed to continue to submit paper claims to the RMC. In addition, the same providers generally treat non-RR Medicare beneficiaries and submit more than 10 claims a month to other Medicare contractors.

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However, ASCA electronic claim filing exceptions apply to Medicare overall, and do not differentiate based on contractors or between RR and non-RR contractors. Providers that submit paper claims to multiple Medicare contractors, including both RR and non-RR Medicare contractors, are subject to ASCA Enforcement Review by each of those contractors.

If a non-RR Medicare contractor 1) determines that a provider does not meet criteria which would permit that provider to continue to submit Medicare claims on paper and 2) notifies the provider that all paper claims submitted on or after a specific date will be denied, then that same decision is to be applied to that provider if submitting paper claims to the RMC even if that provider would not normally submit 10 or more paper claims to the RMC monthly.

If a provider reports that another Medicare contractor has reversed a decision that the provider is ineligible to submit paper claims, the RMC will ask that provider to submit a copy of the reversal letter from that contractor and to hold all new paper claims until such time as the RMC reviews the reversal letter and can advise the provider by letter that they can submit the paper claims.

Effective with the implementation date of CR5606, the Medicare Claims System (MCS) maintainer that prepares the provider files for transfer to the RMC will add ASCA Enforcement Review information when that information is in the non-RR provider files used to prepare the report for the RMC. Once added to the file, information concerning ASCA Enforcement decisions made by the non-RR Medicare contractors (such as providers are ineligible to submit paper claims) will be accessible to the RMC so the same decisions can be applied to the same providers when they bill the RMC.

CR5606 also updates the *Medicare Claims Processing Manual* to eliminate references to Claims Status and Coordination of Benefits ((COB) Medicare HIPAA Contingency Plans and changes to reflect transfer of responsibility for Medigap claims to the COB contractor.

Additional Information

The official instruction, CR5606, issued to your Medicare carrier, A/B MAC, or DME MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1353CP.pdf> on the CMS website.

If you have any questions, please contact your Medicare carrier, A/B MAC, 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.

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