CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1409	**Date: JANUARY 11, 2008**
	Change Request 5857

SUBJECT: Correction to Pub. 100-04, Chapter 17, Section 100.2.1

I. SUMMARY OF CHANGES: The accompanying IOM section to CR 4064 incorrectly transferred information from a Business Requirement to the IOM; This CR will correct that error.

New / Revised Material
Effective Date: February 11, 2008
Implementation Date: February 11, 2008

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

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted 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.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment – Business Requirements

Pub. 100-04	Transmittal: 1409	Date: January 11, 2008	Change Request: 5857

SUBJECT: Correction to Pub. 100-04, Chapter 17, Section 100.2.1

Effective Date: February 11, 2008

Implementation Date: February 11, 2008

I. GENERAL INFORMATION

A. Background: When Pub. 100-04, Chapter 17, Section 100.2.1 was written for the Internet Only Manual with Change Request (CR) 4064, it inadvertently said that claims would be treated as unprocessable should the claim not include the appropriate Competitive Acquisition Program (CAP) modifiers. Per the Business Requirements (BRs) in the CR, claims will be denied when appropriate modifier is not submitted. This CR corrects the IOM to match the BRs.

B. Policy: This CR makes no change in CAP policy.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5857.1	Contractors shall note that the IOM has been corrected to match the BR 4064.2 in CR 4064.	X			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None.										

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	

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

V. CONTACTS

Pre-Implementation Contact(s): Leslie Trazzi at leslie.trazzi@cms.hhs.gov.

Post-Implementation Contact(s): Appropriate Regional Office.

VI. FUNDING

A. *For Fiscal Intermediaries and Carriers,* use the following statement:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

B. *For Medicare Administrative Contractors (MAC),* use the following statement:
The Medicare Administrative Contractor (MAC) is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as changes to the MAC 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. 1409, Issued: 01-11-08, Effective/Implementation: 02-11-08)

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 *(M2)* modifier the claim will be *denied*.

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. Submit a new claim with the complete/correct information.

and

Remark Code MA78 – Missing/incomplete/invalid HCPCS modifier