CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 227 **Date: JULY 9, 2004**

CHANGE REQUEST 3222

I. SUMMARY OF CHANGES: MSN Message 15.19 is updated, and 15.20 is manualized here for the first time. This transmittal restates language included elsewhere verbatim in 100-8. Nothing new is required in this manual.

NOTE: For Part B, MSN message 15.20 is not fully implemented (See CR 3089).

MANUALIZATION - EFFECTIVE DATE: February 3, 2003
***IMPLEMENTATION DATE: August 9, 2004**

Disclaimer for manual changes only: The revision date and transmittal number apply only to the red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will only receive the new/revised information, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	21/50.15 Medical Necessity
N	21/90.15 Necesidad Médica

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Attachment - Business Requirements

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SUBJECT: Local Medical Review Policy/ Local Coverage Determination Medicare Summary Notice (MSN) Message Revision

I. GENERAL INFORMATION

A. Background: Transmittal 63 provided detail on the conversion from local medical review policy (LMRP) to local coverage determinations (LCD). AB-02-155 provided contractors information on what to do if a claim was denied based on an LMRP.

B. Policy: This instruction revises MSN message 15.19 to reflect the current policy conversions from LMRP to LCDs. Furthermore, it manualizes those elements of AB-02-155 that have not been previously manualized. (Reason/Action code N115 has been revised in CR 3227.)

C. Provider Education: None.

II. BUSINESS REQUIREMENTS

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

Requirement #	Requirements	Responsibility
3222.1	Contractors shall give notice to Medicare beneficiaries when claims are denied in part or in whole based on application of an LMRP/LCD.	Contractors
3222.2	Contractors shall ensure that all denials that result from LMRP/LCDs provide the MSN message 15.19 in addition to 15.20 (upon implementation of this CR for FISS FIs and when fully implemented for MCS/VMS carriers as described in CR 3089) and the current applicable message.	Contractors
3222.3	Contractors shall make these messages available in Spanish where appropriate.	Contractors
3222.4	Contractor shall use message 15.19, and 15.20 (upon implementation of this CR for FISS FIs, and when 15.20 is fully implemented for contractors on the MCS/VMS system carriers as described in CR 3089) on both full and partial	Contractors

	denials, whether the denial was made following automated, routine, or complex review.	
3222.5	Contractor shall not use message 15.19 on denials not involving LMRP/LCDs.	Contractors
3222.6	For claims reviewed on a postpayment basis, contractors shall use the message 15.19 and 15.20 (upon implementation of this CR for FISS FIs, and when 15.20 is fully implemented for contractors on the MCS/VMS system carriers as described in CR 3089)	Contractors
3222.7	If sending a letter, contractors shall include the language exactly as contained in MSN message 15.19 and 15.20.	Contractors

III. 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

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: February 3, 2003 **Implementation Date:** August 9, 2004 **Pre-Implementation Contact(s):** Dan Schwartz (dschwartz2@cms.hhs.gov) **Post-Implementation Contact(s):** Regional Offices	**These instructions shall be implemented within your current operating budget.**

50.15 - Medical Necessity

(Rev. 227, Issued 07-09-04) (Effective: February 3, 2004/Implementation: August 9, 2004)

15.1 - The information provided does not support the need for this many services or items.

15.2 - The information provided does not support the need for this equipment.

15.3 - The information provided does not support the need for the special features of this equipment.

15.4 - The information provided does not support the need for this service or item.

15.5 - The information provided does not support the need for similar services by more than one doctor during the same time period.

15.6 - The information provided does not support the need for this many services or items within this period of time.

15.7 - The information provided does not support the need for more than one visit a day.

15.8 - The information provided does not support the level of service as shown on the claim.

15.9 - The Quality Improvement Organization did not approve this service.

15.10 - Medicare does not pay for more than one assistant surgeon for this procedure.

15.11 - Medicare does not pay for an assistant surgeon for this procedure/surgery.

15.12 - Medicare does not pay for two surgeons for this procedure.

15.13 - Medicare does not pay for team surgeons for this procedure.

15.14 - Medicare does not pay for acupuncture.

15.15 - Payment has been reduced because information provided does not support the need for this item as billed.

15.16 - Your claim was reviewed by our medical staff. (NOTE: Add-on to other messages as appropriate.)

15.17 - We have approved this service at a reduced level. (NOTE: Add-on to other messages as appropriate.)

15.18 - Medicare does not cover this service at home.

15.19 - A local medical review policy (LMRP) *or local coverage determination (LCD)* was used when we made this decision. An LMRP*/LCD* provides a guide to assist in determining whether a particular item or service is covered by Medicare. A copy of this policy is available from your local intermediary or carrier by calling the number in the customer service information box on page one. You can compare the facts in your case to the guidelines set out in the LMRP*/LCD* to see whether additional information from your physician would change our decision.

15.20 - The following policies [insert LMRP/LCD ID #(s) and NCD #(s)] were used when we made this decision.

90.15 - Necesidad Médica

(Rev. 227, Issued 07-09-04) (Effective: February 3, 2004/Implementation: August 9, 2004)

15.1 - La información proporcionada no confirma la necesidad de esta cantidad de servicios o artículos.

15.2 - La información proporcionada no confirma la necesidad para este equipo.

15.3 - La información proporcionada no confirma la necesidad para las características especiales de este equipo.

15.4 - La información proporcionada no confirma la necesidad para este servicio o artículo.

15.5 - La información proporcionada no confirma la necesidad por servicios similares por más de un médico durante el mismo periodo.

15.6 - La información proporcionada no confirma la necesidad de estos servicios o artículos en este periodo de tiempo.

15.7 - La información proporcionada no confirma la necesidad de más de una visita al día.

15.8 - La información proporcionada no confirma el nível de servicios según indicado en la reclamación.

15.9 - La Organización para el Mejoramiento de la Calidad no aprobó este servicio.

15.10 - Medicare no paga por más de un asistente de cirujano para este procedimiento.

15.11 - Medicare no paga por el asistente del cirujano por este procedimiento/cirugía.

15.12 - Medicare no paga por dos cirujanos para este procedimiento.

15.13 - Medicare no paga por un equipo de cirujanos para este procedimiento.

15.14 - Medicare no paga por acupuntura.

15.15 - El pago se redujo debido a que la información recibida no confirma la necesidad para este artículo como fue facturado.

15.16 - Su reclamación fue revisada por nuestro personal médico.

15.17 - Hemos aprobado este servicio con un índice de pago reducido.

15.18 - Medicare no cubre este servicio en su casa.

15.19- Una Política Local de Revisión Médica (LMRP, por sus siglas en inglés) o una Determinación de Cobertura Local (LCD, por sus siglas en inglés) fue utilizada cuando se tomó esta decisión. La Política Local de Revisión Médica y la Determinación de Cobertura Local proveen una guía que ayuda a determinar si un artículo o servicio en particular está cubierto por Medicare. Una copia de esta política está disponible en su intermediario o su empresa de seguros Medicare local al llamar al número que aparece en la sección de Servicios al Cliente en la página uno. Usted puede comparar los datos de su caso con las reglas establecidas en la Política Local de Revisión Médica y en la Determinación de Cobertura Local para ver si obteniendo información adicional de su médico pudiera cambiar nuestra decisión

15.20 - Las siguientes políticas [añadir los #s de LMRP/LCD, por sus siglas en inglés y los #s de NCD, por sus siglas en inglés] fueron utilizadas cuando se tomó esta decisión.