CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 298 | **Date: SEPTEMBER 10, 2004**

CHANGE REQUEST 2617

***NOTE**: Transmittal 295 dated September 3, 2004 is rescinded and is replaced with Transmittal 298 dated September 10, 2004. There were four business requirements regarding MSN 18.20 and 18.21 and ANSI reason code A1 with remark codes M86 and M90 that was removed from the Change Request. All other information remains the same.*

I. SUMMARY OF CHANGES: For carriers, reason codes and remark codes have been added to the IOM for more interpretations.

For carriers and intermediaries, a revised Spanish translation for each MSN message has been updated in chapter 18, section 20.8.1 and 18.5, 18.8, 18.9, 18.10, and 18.11 have been deleted because they are no longer needed due to the change in BBA of 1997 to allow annual coverage of screening mammographies for women age 40 or older. Message 18.17 has been revised to state every 2 years instead of 2/3 years because BIPA of 2000 legislation revised Medicare policy to provide coverage of such screening exams once every 2 years unless certain high risk factors are present.

NEW/REVISED MATERIAL - EFFECTIVE DATE: September 25, 2004
***IMPLEMENTATION DATE: September 25, 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	18/20.8.1/MSN Messages
R	18/20.8.2/Remittance Advice Messages
R	21/50.18/Preventive Care

***III. FUNDING:**

These instructions should be implemented within your current operating budget.

IV. ATTACHMENTS:

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

***Medicare contractors only**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 298	Date: September 10, 2004	Change Request 2617

NOTE: Transmittal 295 dated September 3, 2004 is rescinded and is replaced with Transmittal 298 dated September 10, 2004. There were four business requirements regarding MSN 18.20 and 18.21 and ANSI reason code A1 with remark codes M86 and M90 that was removed from the Change Request. All other information remains the same.

SUBJECT: MSN Messages and Reason Codes for Mammography

I. GENERAL INFORMATION

A. Background: The current IOM needs to be updated with more reason codes and remark codes for more interpretation. Also, some current MSN messages need to be deleted and revised due to changes in the BBA of 1997 and BIPA of 2000. New Spanish translation has been revised for current MSN messages.

B. Policy: For carriers, more MSN and ANSI messages have been added to the IOM for better comprehension of the denials. Also, Spanish translation has been revised to reflect current policy. Carriers and intermediaries are to delete messages 18.5, 18.8, 18.9, 18.10 and 18.11 (because they are no longer needed due to the change in the Balanced Budget Act (BBA) of 1997 to allow annual coverage of screening mammographies for women age 40 or older). Message 18.17 shall be revised to state every 2 years instead of 2/3 years because BIPA of 2000 legislation revised Medicare policy to provide coverage of such screening exams once every 2 years unless certain high risk factors are present.

C. Provider Education: 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 must be included in your next regularly scheduled bulletin.

II. BUSINESS REQUIREMENTS

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

Requirement #	Requirements	Responsibility
2617.1	Carriers shall use MSN message 9.2: "This item or service was denied because information required to make payment was missing," for claims submitted with invalid or missing certification number	Carriers

2617.2	Carriers shall use existing reason code 16: “Claim/service lacks information which is needed for adjudication” along with remark code MA128: “Missing/incomplete/invalid six-digit FDA approved, identification number,” when a claim is denied because of lack of FDA identification number, incomplete FDA identification number, or invalid FDA identification number.	Carriers
2617.3	Carriers shall use the existing reason code B6, “This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty” along with remark code N92: “This facility is not certified for digital mammography” when a claim is denied because the facility is not certified to perform digital mammography	Carriers
2617.4	FI and carriers shall update the Spanish translation to the current MSN messages as well as revising 18.17 to reflect current legislation	FI, Carriers
2617.5	FI and carriers shall delete MSN messages 18.5, 18.8, 18.9, 18.10 and 18.11	FI, Carriers
2617.6	FI and carriers shall revise MSN message 18.17 to reflect state every 2 years instead of every 2/3 years.	FI, Carrier

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: September 25, 2004 **Implementation Date: September 25, 2004** **Pre-Implementation Contact(s): Wendy Knarr 410-786-0843(TDD) (Part B) or Linda Gregory 410-786-6138 (Part A)** **Post-Implementation Contact(s): Contact the appropriate RO**	**These instructions should be implemented within your current operating budget.**

20.8.1 - MSN Messages

(Rev.298, Issued: 09-10-04, Effective/Implementation: 09-25-04)

B3-4601.4, A3-3660.10.I

The following messages are used on the MSN.

If the claim is denied because the beneficiary is under 35 years of age*, use the following MSN:*

MSN 18.3:

> Screening mammography is not covered for women under 35 years of age.

The Spanish version of this MSN message should read:

> *Las pruebas de mamografía para mujeres menores de 35 años no están cubiertas.*

If the claim is denied for a woman 35-39 because she has previously received this examination, *use the following MSN*:

MSN 18.6:

> A screening mammography is covered only once for women age 35-39.

The Spanish version of this MSN message should read:

> *Una mamografía de cernimiento es cubierta una vez solamente para mujeres entre las edades de 35-39.*

If the claim is denied because the period of time between screenings for the woman based on age has not passed, *use the following MSN*:

MSN 18.4:

> This service is being denied because it has not been 12 months since your last examination of this kind. (NOTE: Insert appropriate number of months.)

The Spanish version of this MSN message should read:

> *Este servicio se denegó debido a que no han transcurrido 12 meses desde su último examen de este tipo.*

If the claim is denied because the provider is not certified to perform this service (film mammography) or if the claim is denied because the provider is not certified to perform this service (digital mammography), use the following MSN:

MSN 16.2:

> This service cannot be paid when provided in this location/facility.

The Spanish version of this MSN message should read:

> *Este servicio no se puede pagar cuando es suministrado en este sitio/facilidad.*

In addition to the above denial messages, the FI/carrier may add the following:

MSN 18.12:

> Screening mammograms are covered annually for women 40 years of age and older.

The Spanish version of this MSN message should read:

> *El examen de mamografía de cernimiento se cubre una vez al año para mujeres de 40 años de edad o más.*

For Carriers only:

For claims submitted with invalid or missing certification number, use the following MSN:

MSN 9.2:

> *This item or service was denied because information required to make payment was missing.*

The Spanish version of this MSN message should read:

> *Este artículo o servicio fue denegado porque la información requerida para hacer el pago fue omitida.*

20.8.2 - Remittance Advice Messages

(Rev.298, Issued: 09-10-04, Effective/Implementation: 09-25-04)

B3-4601.5, A3- 3660.10.J, SNF-537.I

If the claim is denied because the beneficiary is under 35 years of age, contractors must use existing ANSI X12N 835 claim adjustment reason code/message 6, "The procedure*/revenue code* is inconsistent with the patient's age" along with the remark code M37 (at the line item level), "Service is not covered when the patient is under age 35."

If the claim is denied for a woman 35-39 because she has previously received this examination, contractors must use existing ANSI X12N 835 claim adjustment reason code/message 119, "Benefit maximum for this time period *or occurrence* has been reached" along with the remark code M89 (at the line item level), "Not covered more than once under age 40."

If the claim is denied for a woman age 40 and above because she has previously received this examination within the past 12 months, contractors must use existing ANSI X12N 835 claim adjustment reason code/message 119, "Benefit maximum for this time period *or occurrence* has been reached" along with remark code M90 (at the line item level), "Not covered more than once in a 12-month period."

If the claim is denied because the provider that performed the screening is not certified, use existing ANSI X12N 835 claim adjustment reason code/message B7, "This provider was not certified/eligible to be paid for this procedure/service on this date of service."

For carrier only:

For claims submitted by a facility not certified to perform film mammography, use existing reason B6, "This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty" along with remark code N110 "This facility is not certified for film mammography."

For claims submitted by a facility not certified to perform digital mammograms, use existing reason code B6, "This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty" along with remark code N92,"This facility is not certified for digital mammography."

For claims that were submitted with an invalid or missing certification number, use existing reason code 16, "Claim/service lacks information which is needed for adjudication" along with remark code MA128 "Missing/incomplete/invalid six-digit FDA approved, identification number."

50.18 - Preventive Care

(Rev.298, Issued: 09-10-04, Effective/Implementation: 09-25-04)

AB-02-010

18.1 - Routine examinations and related services not covered.

18.2 - This immunization and/or preventive care is not covered.

18.3 - Screening mammography is not covered for women *under*35 years of age.

18.4 - This service is being denied because it has not been 12 months since your last examination of this kind. (NOTE: Insert appropriate number of months.)

18.6 - A screening mammography is covered only once for women age 35 - 39.

18.7 - Screening pap smears are covered only once every 24 months unless high risk factors are present.

18.12 - Screening mammograms are covered annually for women 40 years of age and older.

18.13 - This service is not covered for beneficiaries under 50 years of age.

18.14 - Service is being denied because it has not been (12, 24, 48) months since your last (test/procedure) of this kind.

18.15 - Medicare only covers this procedure for beneficiaries considered to be at high risk for colorectal cancer.

18.16 - This service is being denied because payment has already been made for a similar procedure within a set time frame.

18.17 - Medicare pays for a screening Pap smear and a screening pelvic examination once every 2 years unless high risk factors are present.

18.18 - Medicare does not pay for this service separately since payment of it is included in our allowance for other services you received on the same day.

18.19 - This service is not covered until after the beneficiary's 50th birthday