CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1578	**Date: AUGUST 15, 2008**
	Change Request 6131

NOTE: Transmittal 1578 is being re-communicated to add AUGUST 15, 2008 to the transmittal page and to include the table of contents to the transmittal page and to the manual update. The Transmittal Number, the Date Issued and all other material remain the same.

SUBJECT: Implementation of a New Claim Adjustment Reason Code (CARC) No.213. "Non-compliance with the Physician Self-referral Prohibition Legislation or Payer Policy"

I. SUMMARY OF CHANGES: This Change Request (CR) instructs contractors and Shared System Maintainers to use the new CARC No. 213, when denying claims based on the non-compliance with the physician self-referral prohibition.

New / Revised Material
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

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	1/Table of Contents/General Billing Requirements
N	1/180/Denial of Claims Due to Violations of Physician Self-Referral Prohibition
N	1/180.1/Background and Policy
N	1/180.2/Denial Code

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: 1578	Date: August 15, 2008	Change Request: 6131

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SUBJECT: Implementation of a New Claim Adjustment Reason Code (CARC) No. 213. "Non-compliance with the Physician Self-referral Prohibition Legislation or Payer Policy"

Effective Date: January 1, 2009

Implementation Date: January 5, 2009

I. GENERAL INFORMATION

A. Background:

Under Section 1877 of the Social Security Act (the Act) (42 U.S.C. §1395nn), a physician may not refer a Medicare patient for certain designated health services (DHS) to an entity with which the physician (or an immediate family member of the physician) has a financial relationship, unless an exception applies. Section 1877 of the Act also prohibits the DHS entity from submitting claims to Medicare, the beneficiary, or any entity for DHS that are furnished as a result of a prohibited referral. The following services are DHS: clinical laboratory services; radiology and certain other imaging services (including MRIs, CT scans and ultrasound); radiation therapy services and supplies; durable medical equipment and supplies; orthotics, prosthetics, and prosthetic devices; parenteral and enteral nutrients, equipment and supplies; physical therapy, occupational therapy, speech-language pathology services; outpatient prescription drugs; home health services and supplies; and inpatient and outpatient hospital services. A "financial relationship" includes both ownership/investment interests and compensation arrangements (for example, contractual arrangements between a hospital and physician for physician services). The statute and regulations enumerate various exceptions to the physician self-referral prohibition. Violations of the statute are punishable by denial of payment for all DHS claims, refunds of amounts collected for DHS claims, and civil money penalties for knowing violations of the prohibition. Applicable regulations are published at 42 C.F.R. Part 411, Subpart J.

B. Policy:

Prior to the publication of the new CARC #213, there was no specific code to describe claims that are denied based on a violation of physician self-referral statute at Section 1877 of the Act. A specific code is appropriate so both the providers of DHS and the industry know that claims are being denied based on the non compliance with the physician self-referral prohibitions. This code should be used any time a claim is denied because the physician (or an immediate family member of the physician) has a financial interest in a DHS provider and fails to meet one of the exceptions available in 42 C.F.R. §§411.355-411.357.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)						
		A/B	DME	FI	CA	RH	Shared-System Maintainers	OTHER

							FISS	MCS	VMS	CWF		
6131.1	Contractors and Shared System Maintainers shall use CARC # 213, when denying or adjusting claims based on the physician self-referral prohibition.	X	X	X	X	X	X	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	
6131.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN 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 one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X	X	X					

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): John.Davis@cms.hhs.gov

Post-Implementation Contact(s): John.Davis@cms.hhs.gov

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers and Regional Home Health Carriers (RHHIs)*:

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.

Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

Table of Contents
(Rev. 1578, 08-15-08)

180 – Denial of Claims Due to Violations of Physician Self-Referral Prohibition

(Rev.1578, Issued: 08-15-08, Effective: 01-01-09, Implementation: 01-05-09)

180.1 – Background and Policy

(Rev.1578, Issued: 08-15-08, Effective: 01-01-09, Implementation: 01-05-09)

Under Section 1877 of the Social Security Act (the Act) (42 U.S.C. §1395nn), a physician may not refer a Medicare patient for certain designated health services (DHS) to an entity with which the physician (or an immediate family member of the physician) has a financial relationship, unless an exception applies. Section 1877 of the Act also prohibits the DHS entity from submitting claims to Medicare, the beneficiary, or any entity for DHS that are furnished as a result of a prohibited referral. The following services are DHS: clinical laboratory services; radiology and certain other imaging services (including MRIs, CT scans and ultrasound); radiation therapy services and supplies; durable medical equipment and supplies; orthotics, prosthetics, and prosthetic devices; parenteral and enteral nutrients, equipment and supplies; physical therapy, occupational therapy, speech-language pathology services; outpatient prescription drugs; home health services and supplies; and inpatient and outpatient hospital services. A "financial relationship" includes both ownership/investment interests and compensation arrangements (for example, contractual arrangements between a hospital and a physician for physician services). The statute and regulations enumerate various exceptions to the physician self-referral prohibition. Violations of the statute are punishable by denial of payment for all DHS claims, refunds of amounts collected for DHS claims, and civil money penalties for knowing violations of the prohibition. Applicable regulations are published at 42 C.F.R. Part 411, Subpart J.

180.2 – Denial Code

(Rev.1578, Issued: 08-15-08, Effective: 01-01-09, Implementation: 01-05-09)

Prior to the publication of the new CARC #213, there was no specific code to describe claims that are denied based on a violation of the physician self-referral statute at Section 1877 of the Act. A specific code is appropriate so both the providers of DHS and the industry know that claims are being denied based on the non compliance with the physician self-referral prohibitions. This code should be used any time a claim is denied because the physician (or an immediate family member of the physician) has a financial interest in a DHS provider and fails to meet one of the exceptions available in 42 C.F.R. §§411.355-411.357.