

CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 472

Department of Health &
Human Services

Center for Medicare and
&
Medicaid Services

Date: FEBRUARY 11,
2005

Change Request 3628

SUBJECT: Revisions to Payment for Services Provided Under a Contractual Arrangement - - Carrier Claims Only

I. SUMMARY OF CHANGES: This instruction makes a slight revision to the language in section 30.2.7, Medicare Claims Processing Manual, Chapter 1 - General Billing Requirements on payment for services provided under a contractual arrangement. This change is a result of the language, pertaining to section 952 of the MMA on revisions to the reassignment provisions, published in the November 15, 2004 Physician Fee Schedule final rule. Instead of stating that the contractual arrangement between the entity and the physician or other person should include the following program integrity safeguards, we are now stating that the entity and the physician or other person are subject to the following program integrity safeguards. In addition, it is not necessary for the program integrity safeguards to be included in the written contract; but, the entity billing and receiving payment and the person reassigning his or her billing and payment rights are both responsible for compliance with the program integrity safeguards. Section 30.2.1 has been revised to reflect the change made in the new 30.2.7, payment to entities for services under a contractual arrangement. The old facility exception and health care delivery system clinic exception have been replaced by the new contractual arrangement exception.

NEW/REVISED MATERIAL :

EFFECTIVE DATE : January 1, 2005

IMPLEMENTATION DATE : March 15, 2005

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
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R	1/30/30.2.1/Exceptions to Assignment of Provider's Right to Payment - Claims Submitted to FIs and Carriers
R	1/30/30.2.7/Payment for Services Provided Under a Contractual Arrangement - - Carrier Claims Only

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 472	Date: February 11, 2005	Change Request 3628
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SUBJECT: Revisions to Payment for Services Provided Under a Contractual Arrangement – Carrier Claims Only

I. GENERAL INFORMATION

A. Background: This instruction makes a slight revision to section 30.2.7 (Payment for services provided under a contractual arrangement), of the Medicare Claims Processing Manual, Chapter 1 on General Billing Requirements. These instructions do not apply to billing agents. For instructions on payment to agents see section 30.2.4. This change is a result of clarifying reassignment policy language that was included in the Physician Fee Schedule final rule, published in November 2004.

B. Policy: A carrier should make payment to an entity (i.e., a person, group, or facility enrolled in the Medicare program) that submits a claim for services provided by a physician or other person under a contractual arrangement with that entity, regardless of where the service is furnished. Thus, the service can be furnished on or off the premises of the entity submitting the bill and receiving payment. The entity receiving payment and the physician or other person that furnished the service are both subject to the following program integrity safeguard requirements:

1. The entity receiving payment and the person that furnished the service are jointly and severally responsible for any Medicare overpayment to that entity; and,
2. The person furnishing the services has unrestricted access to claims submitted by an entity for services provided by that person.

C. Provider Education: A Medlearn Matters 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 one week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement

"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)					
		F	R	C	D	Shared System	Other
		I	H	a	M	Maintainers	
		U	S	F			

							F I S S	M C S	V M S	C W F	
3628.1	Medicare contractors shall notify their providers and suppliers that are affected by this change in the reassignment rules.	X		X							

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

<p>Effective Date*: January 1, 2005</p> <p>Implementation Date: March 15, 2005</p> <p>Pre-Implementation Contact(s): David Walczak (410) 786-4475</p> <p>Post-Implementation Contact(s): David Walczak (410) 786-4475</p>	<p>No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.</p>
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30.2.1 - Exceptions to Assignment of Provider's Right to Payment - Claims Submitted to FIs and Carriers

(Rev. 472, Issued: 02-11-05, Effective: 01-01-05, Implementation: 03-15-05)

A - Payment to Government Agency

Medicare payment for the services of a provider is not made to a governmental agency or entity except when payment to the governmental agency or entity is permissible under the other listed reassignment exceptions, e.g., where the agency is the employer of the physician.

B - Payment Pursuant to Court Order

The Medicare program may make payment in accordance with an assignment established by, or pursuant to the order of, a court of competent jurisdiction. The assignment must satisfy the conditions set forth in §30.2.

C - Payment to Agent

The Medicare program may make payment, in the name of the provider, to an agent who furnishes billing or collection services. The payment arrangement must satisfy the conditions in §30.2.4.

D - Payment to Employer

The carrier may pay the employer of the physician or other supplier if the physician or other supplier is required, as a condition of his employment, to turn over to his employer the fees for his services. (See §30.2.6.)

E – *Payment for Services Provided Under a Contractual Arrangement*

The carrier may make payment to an entity enrolled in the Medicare program for services provided by a physician or other person under a contractual arrangement with that entity. The services may be furnished on or off the premises of the entity submitting the claim. Both, the entity submitting the claim and receiving payment and the physician or other person under contract are subject to certain program integrity requirements. (See §30.2.7.)

F – Payment to Physician for Purchased Diagnostic Tests

The carrier may pay a physician (or a physician's medical group) for diagnostic laboratory tests (other than clinical diagnostic laboratory tests), which that physician (or group) purchases from an independent physician, medical group, or other supplier. Cannot mark-up the test. Must accept as payment in full the lower of the purchase price or the fee schedule amount. (See §30.2.9.)

G - Payment to Supplier for Diagnostic Test Interpretations

The carrier may pay a person or entity that provides diagnostic tests for purchased diagnostic test interpretations, which that person or entity purchases from an independent physician or medical group, if specified requirements are met. Three separate entities: (1) ordering entity, (2) entity furnishing the diagnostic test, and (3) entity doing the test interpretation. (See §30.2.9.1.)

H - Payment Under Reciprocal Billing Arrangements

The carrier may pay the patient's regular physician for services provided to his/her patients by another physician on an occasional reciprocal basis. (See §30.2.10.)

I - Payment Under Locum Tenens Arrangements

The carrier may pay the patient's regular physician for services of a locum tenens physician during the absence of the regular physician where the regular physician pays the locum tenens on a per diem or similar fee-for-time basis, and certain other requirements are met. (See §30.2.11.)

30.2.7 - Payment for Services Provided Under a Contractual Arrangement - Carrier Claims Only

(Rev. 472, Issued: 02-11-05, Effective: 01-01-05, Implementation: 03-15-05)

A carrier may make payment to an entity (i.e., a person, group, or facility) enrolled in the Medicare program that submits a claim for services provided by a physician or other person under a contractual arrangement with that entity, regardless of where the service is furnished. Thus, the service may be furnished on or off the premises of the entity submitting the bill *and receiving payment. The entity receiving payment and the physician or other person that furnished the service are both subject to the following program integrity safeguard requirements:*

- 1. The entity receiving payment and the person that furnished the service are jointly and severally responsible for any Medicare overpayment to that entity; and,*
- 2. The person furnishing the service has unrestricted access to claims submitted by an entity for services provided by that person.*