

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-04 Medicare Claims Processing</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 1732</b>	<b>Date: May 8, 2009</b>
	<b>Change Request 6429</b>

**SUBJECT: Pricing Claims for Services Rendered in Place of Service Home**

**I. SUMMARY OF CHANGES:** For claims processed on or after October 5, 2009, this change will allow claims for services payable under the Medicare Physician Fee Schedule and anesthesia services rendered in place of service (POS) Home - 12, or for any other POS the contractor currently treats as POS Home, to price correctly using 9-digit ZIP codes.

**New / Revised Material**

**Effective Date: For claims processed on or after October 5, 2009**

**Implementation Date: October 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	Chapter 1/TOC/General Billing Requirements
R	Medicare Claims Processing Manual/Chapter 1/General Billing Requirements/Table of Contents
R	Chapter 1/Section 10.1.1/Payment Jurisdiction Among Contractors for Services Paid Under the Physician Fee Schedule and Anesthesia Services
R	Chapter 1/Section 10.1.1.1/Claims Processing Instructions for Payment Jurisdiction for Claims Received on or after April 1, 2004

### **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

<b>Pub. 100-04</b>	<b>Transmittal: 1732</b>	<b>Date: May 8, 2009</b>	<b>Change Request: 6429</b>
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**SUBJECT:** Pricing Claims for Services Rendered in Place of Service Home

**Effective Date:** For claims processed on or after October 5, 2009

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## I. GENERAL INFORMATION

**A. Background:** For services payable under the Medicare Physician Fee Schedule and anesthesia services, claims for services rendered in place of service (POS) Home – 12, or for any other POS the contractor currently treats as POS home, must be priced according to the payment locality where the service is rendered. In order to appropriately determine that payment locality in an automated fashion, contractors need to be able to make use of the 9-digit ZIP code for the beneficiary’s address. This instruction allows for that change to be implemented.

**B. Policy:** For services payable under the Medicare Physician Fee Schedule and anesthesia services, contractors are to price claims according to payment localities. This policy had not changed.

## II. BUSINESS REQUIREMENTS TABLE

*Use “Shall” to denote a mandatory requirement*

Number	Requirement	Responsibility (place an “X” in each applicable column)								
		A / B  M A C	D M E  M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers			
						F I S S	M C S	V M S	C W F	
6429.1	For services payable under the MPFS and anesthesia services, claims for services rendered in place of service (POS) Home – 12, or for any other POS the contractor currently treats as POS home, when a 4-digit extension is required according to the ZIP code file, the standard system shall use the 9-digit ZIP code on the beneficiary file, if available, in order to automatically determine the correct payment locality.						X			
6429.2	For services payable under the MPFS and anesthesia services, claims for services rendered in place of service (POS) Home – 12, or for any other POS the contractor currently treats as POS home, the standard system shall notify the carrier/A/B MAC if a 9-digit ZIP code is not included on the beneficiary file when required by the CMS ZIP code file in order to price the claim.	X			X		X			
6429.2.1	Using the United State Postal Service Web site, the	X			X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	carrier/A/B MAC shall determine the 9-digit ZIP code based on the beneficiary address.										
6429.2.2	The carrier/A/B MAC shall use that ZIP code to determine the correct payment locality for the claim for pricing purposes and to process the claim.	X			X						
6429.3	A/B MACs processing claims described in this CR shall take necessary steps to ensure that the claims for services rendered in the physical location for which they are the MAC are priced and processed correctly applying appropriate edits as necessary.	X									

### III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	None.										

### IV. SUPPORTING INFORMATION

**Section 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

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

### V. CONTACTS

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**Post-Implementation Contact(s):** Leslie Trazzi, leslie.trazzi@cms.hhs.gov

## **VI. FUNDING**

### **Section A: For *Fiscal Intermediaries (FIs)*, *Regional Home Health Intermediaries (RHHIs)*, and/or *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.

# Medicare Claims Processing Manual

## Chapter 1 - General Billing Requirements

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### Table of Contents *(Rev.1732, 05-08-09)*

10.1.1 - Payment Jurisdiction Among *Contractors* for Services Paid Under the Physician Fee Schedule and Anesthesia Services

### **10.1.1 - Payment Jurisdiction Among *Contractors* for Services Paid Under the Physician Fee Schedule and Anesthesia Services**

***(Rev.1732, Issued: 05-08-09, Effective: 10-05-09, Implementation: 10-05-09)***

The jurisdiction for processing a request for payment for services paid under the Medicare Physician Fee Schedule (MPFS) and for anesthesia services is governed by the payment locality where the service is furnished and will be based on the ZIP code. Though a number of additional services appear on the MPFS database, these payment jurisdiction rules apply only to those services actually paid under the MPFS and to anesthesia services. (For example, it does not apply to clinical lab, ambulance or drug claims.)

Effective for claims received on or after April 1, 2004, *contractors* must use the ZIP code of the location where the service was rendered to determine *contractor* jurisdiction over the claim and the correct payment locality. Effective for dates of service on or after October 1, 2007, except for services provided in POS *home – 12*, if they are not already doing so, contractors shall use the CMS *ZIP* code file along with the *ZIP* code submitted on the claim with the address that represents where the service was performed to determine the correct payment locality. *(See §10.1.1B for changes to processing services rendered in POS home - 12 and §10.1.1.1 for instructions for when a 9-digit ZIP code is required.)*

When a physician, practitioner, or supplier furnishes physician fee schedule or anesthesia services in payment localities that span more than one *contractor's* service area (e.g., provider has separate offices in multiple localities and/or multiple *contractors*), separate claims must be submitted to the appropriate area *contractor* for processing. For example, when a physician with an office in Illinois furnishes services outside the office setting (e.g., home, hospital, SNF visits) and that out-of-office service location is in another *contractor's* service area (e.g., Indiana), the *contractor that* processes claims for the payment locality where the out of office service was furnished has jurisdiction for that service. It is the *contractor* with the correct physician fee schedule pricing data for the location where the service was furnished. In the majority of cases, the physician fee schedule or anesthesia services provided by physicians are within the same *contractor* jurisdiction that the physicians' office(s) is/are located.

Although pricing rules for services paid under the MPFS remain in effect, effective for claims with dates of service on or after January 25, 2005, suppliers (including laboratories, physicians, and independent diagnostic testing facilities [IDTFs]) must bill their local *contractor* for all purchased diagnostic tests/interpretations, regardless of the location where the purchased service was furnished. Beginning in 2005, and in each subsequent calendar year (CY) thereafter, CMS will provide *contractors* with a national abstract file containing Healthcare Common Procedural Coding System (HCPCS) codes that are payable under the MPFS as either a purchased test or interpretation for the year. In addition, CMS will make quarterly updates to the abstract file to add and/or delete codes, as needed, in conjunction with the MFSDB quarterly updates. As with all other services payable under the MPFS, the ZIP code of the locality in which the service was

furnished determines the payment amount. Refer to §30.2.9 for the supplier billing requirements applicable to purchased diagnostic services.

#### **A. Multiple Offices**

In states with multiple physician fee schedule pricing localities or where a provider has multiple offices located in two or more states, or there is more than one *contractor* servicing a particular state, physicians, suppliers and group practices with multiple offices in such areas must identify the specific location where office-based services were performed. This is to insure correct claim processing jurisdiction and/or correct pricing of MPFS and anesthesia services. The *contractor* must ensure that multiple office situations are cross-referenced within its system. If a physician/group with offices in more than one MPFS pricing locality fails to specify the location where an office-based service was furnished, the *contractor* will return/reject the claim as unprocessable.

Physicians, suppliers, and group practices that furnish physician fee schedule services at more than one office/practice location may submit their claims through one office to the *contractor* for processing. However, the specific location where the services were furnished must be entered on the claim so the *contractor* has the ZIP code, can determine the correct claims processing jurisdiction, and can apply the correct physician fee schedule amount.

#### **B. Service Provided at a Place of Service Other than Home-12 or Office-11**

For claims submitted prior to April 1, 2004, in order to determine claims jurisdiction, Medicare approved charges, Medicare payment amounts, Medicare limiting charges and beneficiary liability, Part B fee-for-service claims for services furnished in other than in an office setting or a beneficiary's home must include information specifying where the service was provided.

Effective for claims received on or after April 1, 2004, claims for services furnished in all places of service other than a beneficiary's home must include information specifying where the service was provided. *Contractors* must use the address on the beneficiary files when POS is home - 12, or any other mechanism currently in place to determine pricing locality when POS is home – 12. *Contractors* shall take this same action for any other POS codes they currently treat as POS home.

*Effective for claims processed on or after October 5, 2009, for services rendered in POS home -12, or for any other POS the contractor currently treats as POS home, when alerted by the shared system that a 9-digit ZIP code is required according to the CMS ZIP code file, and a 9-digit ZIP code is not available on the beneficiary file, the contractor shall determine that ZIP code by using the United States Postal Service Web site. They shall use that ZIP code to determine the correct payment locality for the claim for pricing purposes.*



*A/B MACs processing claims these claims shall take necessary steps to ensure that the claims for services rendered in the physical location for which they are the MAC are priced and processed correctly applying appropriate edits as necessary.*

### **C. Outside *Contractor* Jurisdiction**

If *contractors* receive claims outside of their jurisdiction, they must follow resolution procedures in accordance with the instructions in 10.1.9. If they receive a significant volume or experiences repeated incidences of misdirected Medicare Physician Fee Schedule or anesthesia services from a particular provider, an educational contact may be warranted.

### **D. HMO Claims**

For services that HMOs are not required to furnish, *contractors* process claims for items or services provided to an HMO member over which they have jurisdiction in the same manner as they process other Part B claims for items or services provided by physicians or suppliers. Generally, the physician/supplier who provides in-plan services to its HMO members submits a bill directly to the HMO for payment and normally does not get involved in processing the claim. However, in some cases, claims for services to HMO members are also submitted to *contractors*, e.g., where claims are received from physicians for dialysis and related services provided through a related dialysis facility.

#### **10.1.1.1 - Claims Processing Instructions for Payment Jurisdiction for Claims Received on or after April 1, 2004**

*(Rev.1732, Issued: 05-08-09, Effective: 10-05-09, Implementation: 10-05-09)*

Provided below are separate instructions for processing electronic claims using the ANSI X12N 837 format and paper claims. No changes will be required in either submission or processing for claims for services subject to jurisdictional pricing for services paid under the Medicare physician fee schedule and anesthesia services submitted on the National Standard Format. See §30.2.9 and Chapter 12 for additional information on purchased tests.

#### **A. ANSI X12N 837 P Electronic Claims**

Note that the following instructions do not apply to services rendered at POS home -12. For services rendered at POS home – 12, use the address on the beneficiary file *for the beneficiary's home* (or wherever else the beneficiary information is currently being stored) to determine pricing locality. *(See §10.1.1 for changes to processing for services rendered at POS home – 12.)*

Per the implementation guide of the 4010/4010A1 version of the ANSI X12N 837 P, it is acceptable for claims to contain the code for POS home and any number of additional POS codes. If different POS codes are used for services on the claim, a corresponding service facility location and address shall be entered for each service at the line level, if that location is different from the billing provider, pay-to-provider, or claim level service

facility location. Pay the service based on the ZIP code of the service facility location, billing provider address, or pay-to provider address depending upon which information is provided.

Refer to the current implementation guide of the ANSI X12N 837 P to determine how information concerning where a service was rendered, the service facility location shall be entered on a claim. Per the documentation, though an address may not appear in the loop named “service facility address,” the information may still be available on the claim in a related loop.

**EXAMPLE:** On version 4010/4010A of the ANSI X12N 837 P electronic claim format, the Billing Provider loop 2010AA is required and therefore shall always be entered. If the Pay-To Provider Name and Address loop 2010AB is the same as the Billing Provider, only the Billing Provider will be entered. If no Pay-To Provider Name and Address is entered in loop 2010AB, and the Service Facility Location loop 2310D (claim level) or 2420C (line level) is the same as the Billing Provider, then only the Billing Provider will be entered. In this case, price the service based on the Billing Provider ZIP code.

**EXCEPTION:** For DMERC claims - Effective for claims received on or after 1/1/05, the Standard System shall not evaluate the 2010AA loop for a valid place of service. If there is no entry in the 2420C loop or the 2310D loop, the claim shall be returned as unprocessable.

- If the Pay-To Provider Name and Address loop 2010AB is not the same as the Billing Provider, both will be entered. If the Service Facility Location loop 2310D is not the same as the Billing Provider or the Pay-To Provider, the Service Facility Location loop 2310D (claim level) will be entered. Price the service based on the ZIP code in Service Facility Location loop 2310D, unless the 2420C (line level) is also entered. In that case, price the service based on the ZIP code in the Service Facility Location loop 2420C (line level) for that line.

Make any necessary accommodations in claims processing systems to accept either the header level or line level information as appropriate and process the claims accordingly. No longer use the provider address on file when the POS is office to determine pricing locality and jurisdiction. Appropriate information from the claim shall always be used.

In the following situation, per the information in the 4010/4010A1 version of the ANSI X12N 837 P, the place where the service was rendered cannot be identified from the claim. In this situation, price all services on the claim based on the ZIP code in the Billing Provider loop. Continue to take this action until such time as the ASC documentation is revised to allow for identification of where the service was rendered to be identified from the claim.

If the Pay-To Provider Name and Address loop 2010AB is not the same as the Billing Provider, both will be entered. If the Service Facility Location loop 2310D (claim level) or 2420C (line level) is the same as the Billing Provider or the Pay-To Provider, no entry

is required per version 4010/4010A1 for Service Facility Location loop 2310D (claim level) or 2420C (line level).

When the same POS code and same service location address is applicable to each service line on the claim, the service facility location name and address shall be entered at the claim level loop 2310D.

In general, when the service facility location name and address is entered only at the claim level, use the ZIP code of that address to determine pricing locality for each of the services on the claim. When entered at the line level, the ZIP code for each line shall be used.

If the POS code is the same for all services, but the services were provided at different addresses, each service shall be submitted with line level information. This will provide a ZIP code to price each service on the claim.

## **B. Paper Claims Submitted on the Form CMS-1500**

Note that the following instructions do not apply to services rendered at POS home – 12 or any other places of service contractors consider to be *home*. (See §10.1.1.1)

It is acceptable for claims to contain POS home and an additional POS code. No service address for POS home needs to be entered for the service rendered at POS home in this situation as the address will be drawn from the beneficiary file (or wherever else the carrier is currently storing the beneficiary information) and the information on the claim will apply to the other POS.

*Except for the situation described above, the* provider shall submit separate claims for each POS. The specific location where the services were furnished shall be entered on the claim. Use the ZIP code of the address entered in Item 32 to price the claim. If multiple POS codes are submitted on the same claim, treat assigned claims as unprocessable and follow the instructions in §80.3.1. Carriers shall continue to follow their current procedures for handling unprocessable unassigned claims.

Use the following messages:

Remittance Advice – Adjustment Reason Code 16 – “Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Remark Code –M77 – “Missing/incomplete/invalid place of service.”

MSN - 9.2 – “This item or service was denied because information required to make payment was missing.”

If the contractor receives a fee-for-service claim containing one or more services for which the MPFS payment locality is in another carrier's jurisdiction, handle in accordance with the instructions in §10.1.9. If you receive a significant volume or experience repeated incidences of misdirected Medicare Physician Fee Schedule claims/services from a particular provider, an educational contact may be warranted. Handle misdirected claims/services for HMO enrollees in accordance with §10.1.1.C and D.

### **C. Determining the Correct Payment Locality for Services Paid Under the Medicare Physician Fee Schedule (MPFS) and Anesthesia Services When Rendered in a Payment Locality that Crosses ZIP Code Areas**

Per the instructions above, Medicare carriers have been directed to determine the payment locality for services paid under the MPFS and anesthesia services by using the ZIP code on the claim of where the service was performed. It has come to the attention of CMS that some ZIP codes fall into more than one payment locality. The CMS ZIP code file uses the convention of the United States Postal Service, which assigns these ZIP codes into dominant counties. In some cases, though the service may actually be rendered in one county, per the ZIP code it is assigned into a different county. This causes a payment issue when each of the counties has a different payment locality and therefore a different payment amount. Note that as the services on the Purchased Diagnostic Test Abstract file are payable under the MPFS, the 9-digit ZIP code requirements will also apply to those codes.

Effective for dates of service on or after October 1, 2007, CMS shall provide a list of the ZIP codes that cross localities as well as provide quarterly updates when necessary. The CMS ZIP code file shall be revised to two files: one for 5-digit ZIP codes (ZIP5) and one for 9-digit ZIP codes (ZIP9). Providers performing services paid under the MPFS, anesthesia services, or any other services as described above, in those ZIP codes that cross payment localities shall be required to submit the 9-digit ZIP codes on the claim for where the service was rendered. Claims for services payable under the MPFS and anesthesia services that are NOT performed in one of the ZIP code areas that cross localities may continue to be submitted with 5-digit ZIP codes. Claims for services other than those payable under the MPFS or anesthesia services may continue to be submitted with 5-digit ZIP codes.

Beginning in 2009, contractors shall maintain separate ZIP code files for each year which will be updated on a quarterly basis. Claims shall be processed using the correct ZIP code file based on the date of service submitted on the claim.

It should be noted that though some states consist of a single pricing locality, ZIP codes can overlap states thus necessitating the submission of the 9-digit ZIP code in order to allow the process to identify the correct pricing locality.

Claims received with a 5-digit ZIP code that is one of the ZIP codes that cross localities and therefore requires a 9-digit ZIP code to be processed shall be treated as unprocessable.

For claims received that require a 9-digit ZIP code with a 4 digit extension that does not match a 4-digit extension on file, manually verify the 4-digit extension to identify a potential coding error on the claim or a new 4-digit extension established by the U.S. Postal Service (USPS). ZIP code and county information may be found at the USPS Web site at <http://www.usps.com/>, or other commercially available sources of ZIP code information may be consulted. If this process validates the ZIP code, the claim may be processed. The “Revision to Payment Policies Under the Physician Fee Schedule” that is published annually in the Federal Register, or any other available resource, may be used to determine the appropriate payment locality for the ZIP code with the new 4-digit extension. If this process does not validate the ZIP code, the claim shall be treated as unprocessable.

The following Remittance Advice and Remark Code messages shall be returned for the unprocessable claims:

Adjustment Reason Code 16 – Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Additional information is supplied using remittance advice remark codes whenever appropriate.

Remark Code MA 130 – Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Submit a new claim with the complete/correct information.

Remark Code MA114 – Missing/incomplete/ information on where the services were furnished.

Should a service be performed in a ZIP code area that does not require the submission of the 9-digit ZIP code, but the 4-digit extension has been included anyway, carriers shall price the claim using the carrier/locality on the ZIP5 file and ignore the 4-digit extension.

Effective for claims processed on or after July 6, 2009, the standard system shall make revisions to allow contractors to add valid 4-digit extensions not included on the current quarter’s 9-digit ZIP code file until they appear on a quarterly file.

Contractors shall reprocess claims brought to their attention if the next CMS quarterly file is received and the locality determination on a new 4-digit extension is different than that made manually by the contractor thus having inadvertently caused incorrect payment.

## D. ZIP9 Code to Locality Record Layout

Below is the ZIP9 code to locality file layout. Information on the naming conventions, availability, how to download the ZIP5 and ZIP9 files, and the ZIP5 layout can be found in Pub. 100-04, Chapter 15, section 20.1.6.

### ZIP9 Code to Locality Record Layout

(Effective for dates of service on or after October 1, 2007.)

<u>Field Name</u>	<u>Beg. Position</u>	<u>End Position</u>	<u>Length</u>	<u>Comments</u>
State	1	2	2	
ZIP Code	3	7	5	
Carrier	8	12	5	
Pricing Locality	13	14	2	
Rural Indicator	15	15	1	blank=urban, R=rural, B=super rural
Filler	16	20	5	
Plus Four Flag	21	21	1	0 = no +4 extension, 1 = +4 extension
Plus Four	22	25	4	
Filler	26	75	50	
Year/Quarter	76	80	5	YYYYQ