CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 464 **Date: FEBRUARY 4, 2005**

CHANGE REQUEST 3694

SUBJECT: Implementation of the Abstract File for Purchased Diagnostic Tests/Interpretations (Supplemental to CR 3481)

I. SUMMARY OF CHANGES: This instruction replaces Business Requirement 3481.11 in Change Request (CR) 3481 and notifies the carriers not to implement the physician billing instructions specified in CR3481 for purchased services performed outside of the carrier's jurisdiction, until further notice. All other instructions specified by CR 3481 remain in effect.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: April 1, 2005
IMPLEMENTATION DATE: April 4, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	1/10.1.1/Payment Jurisdiction Among Local Carriers for Services Paid Under the Physician Fee Schedule and Anesthesia Services
R	1/10.1.1.2/Payment Jurisdiction for Purchased Services
R	1/30.2.9/Payment to Physician or Other Supplier for Purchased Diagnostic Tests – Claims Submitted to Carriers
R	1/30.2.9.1/Payment to Supplier of Diagnostic Tests for Purchased Interpretations

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

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

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 464	Date: February 4, 2005	Change Request 3694

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NOTE: This instruction replaces Business Requirement 3481.11 in Change Request (CR) 3481 and notifies the carriers not to implement the physician billing instructions specified in CR 3481 for purchased services performed outside of the carrier's jurisdiction, until further notice. All other instructions specified by CR 3481 remain in effect.

The VIPS shared system and associated Part B Carriers are waived from implementing this CR due to their upcoming transition to the MCS system. Carriers are required to implement the CR once they transition to MCS.

I. GENERAL INFORMATION

A. Background: In accordance with CR 3481 (Transmittal 341, issued on October 29, 2004), the Centers for Medicare and Medicaid Services (CMS) plans to implement a national abstract file of the Medicare Physician Fee Schedule (MPFS) containing Healthcare Common Procedural Coding System (HCPCS) codes billable as a purchased diagnostic test/interpretation, for every locality throughout the country. Effective with the implementation of the abstract file in April 2005, carrier jurisdiction rules for purchased diagnostic tests/interpretations will be changed to allow suppliers to bill their local carriers for these services and receive the correct payment amount, regardless of the location where the service was performed. Carrier jurisdictional pricing rules for all other services payable under the MPFS will remain in effect.

In CR 3481, the CMS directed the carriers to accept and process claims for purchased diagnostic tests/interpretations when billed by suppliers (including laboratories, physicians, and Independent Diagnostic Testing Facilities [IDTF]) enrolled in the carrier's jurisdiction, regardless of where the service was furnished, effective April 1, 2005.

Since the issuance of this instruction, the CMS has become aware of a potential problem with processing claims for purchased tests/interpretations performed outside of the local carrier's jurisdiction when billed by an IDTF or a physician, due to the current Common Working File (CWF) locality (74x1) edit criteria. Effective April 1, 2005, the CWF locality edit criteria will be changed to bypass Specialty Type '47' (IDTF) claims. However, until further notice, the CMS plans to delay the implementation of the billing instructions specified in CR3481 for purchased diagnostic service claims submitted by physicians due to an additional locality reporting issue.

B. Policy: Effective April 1, 2005, the CWF will bypass the locality edit (74x1) for specialty type '47' (IDTF) and '69' (independent clinical diagnostic laboratory) claims. In accordance with CR3630, effective January 25, 2005, carriers should accept and process claims for purchased diagnostic tests/interpretations when billed by suppliers (including laboratories, physicians, and IDTF) enrolled in their jurisdiction, regardless of the location where the service was performed. (**NOTE:** Suppliers billing for purchased diagnostic tests/interpretations must meet all other enrollment criteria, and must be eligible to bill for the purchased component of the test.) Effective April 1, 2005, carriers must use the national abstract file for purchased diagnostic tests/interpretations to price claims for purchased diagnostic services, based on the ZIP code of the location where the service was rendered, when submitted by a laboratory or IDTF, in accordance with CR 3481. In accordance with the Internet Only Manual Publication 100-04, Chapter 16, §40.2, carriers should continue to pay the lower of the billed charge or the Medicare Physician Fee Schedule amount when an independent laboratory bills for the technical component (TC) of a physician pathology service purchased from a separate physician or supplier. Until further notice, carriers must pay the local rate for purchased diagnostic service claims when submitted by a physician enrolled in the carrier's jurisdiction.

Carriers must not implement the billing instructions specified in CR 3481 for physician claims. In lieu of these instructions, physicians must continue to report their name and service facility location on claims for purchased tests/interpretations performed outside of the local carrier's jurisdiction and must use their own provider identification number (PIN) to bill for both the purchased portion of the test and the portion of the test that they performed, in accordance with CR 3630 (Transmittal 415, issued on December 23, 2004). Physicians must continue to bill their local carrier for theses services.

NOTE: A claim for a purchased test/interpretation submitted with an out-of-jurisdiction locality and a physician specialty type will be rejected by the CWF locality edit (74x1). If a physician claim for a purchased test/interpretation is rejected due to the locality edit, the carrier should follow established Medicare procedures for denying the claim.

The CMS will provide further direction to the carriers concerning the implementation of the abstract file for purchased tests/interpretations for physician claims in a future change request.

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)								
						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3694.1	Effective April 1, 2005, the CWF shall bypass the locality edit (74x1) for specialty type '47' (IDTF) and '69' (independent clinical diagnostic laboratory) claims.			X					X	
3694.2	Effective April 1, 2005, carriers shall use the national abstract file for purchased diagnostic tests/interpretations to price claims for the purchased diagnostic services, based on the ZIP code of the location where the service was rendered, when submitted by a laboratory or IDTF, in accordance with CR3481.			X						
3694.3	Until further notice, carriers shall pay the local rate for purchased tests/interpretations performed outside of their service area when billed a physician enrolled in their jurisdiction.			X						
3694.4	Carriers shall educate physicians to continue to report their name and service facility location on claims for purchased tests/interpretations performed outside of the local carrier's jurisdiction and to use their own PIN to bill for both the purchased portion of the test and the portion of the test that they performed, in accordance with CR3630 (Transmittal 415, issued on December 23, 2004).			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

Effective Date*: April 1, 2005 **Implementation Date:** April 4, 2005 **Pre-Implementation Contact(s):** Susan Webster, (410) 786-3384 **Post-Implementation Contact(s):** Contact the appropriate regional office.	**Medicare contractors shall implement these instructions within their current operating budgets.**

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

10.1.1 - Payment Jurisdiction Among Local Carriers for Services Paid Under the Physician Fee Schedule and Anesthesia Services

(Rev. 464, Issued: 02-04-05, Effective: 04-01-05, Implementation: 04-04-05)

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, carriers must use the ZIP code of the location where the service was rendered to determine carrier jurisdiction over the claim and the correct payment locality.

When a physician, practitioner, or supplier furnishes physician fee schedule or anesthesia services in payment localities that span more than one carrier's service area (e.g., provider has separate offices in multiple localities and/or multiple carriers), separate claims must be submitted to the appropriate area carriers 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 carrier's service area (e.g., Indiana), the carrier which processes claims for the payment locality where the out of office service was furnished has jurisdiction for that service. It is the carrier 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 carrier 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 carrier 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 carriers 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 carrier 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 carrier 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 or a multi-carrier state fails to specify the location where an office-based service was furnished, the carrier 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 carrier for processing. However, the specific location where the services were furnished must be entered on the claim so the carrier 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. Carriers must use the address on the beneficiary files when place of service (POS) is home - 12, or any other mechanism currently in place to determine pricing locality when POS is home – 12.

C. Outside Carrier Jurisdiction

If carriers 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, carriers 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 carriers, e.g., where claims are received from physicians for dialysis and related services provided through a related dialysis facility.

10.1.1.2 - Payment Jurisdiction for Purchased Services

(Rev. 464, Issued: 02-04-05, Effective: 04-01-05, Implementation: 04-04-05)

Diagnostic tests and their interpretations are paid on the MPFS. Therefore, they are subject to the same payment rules as all other services paid on the MPFS. Additional explanation is provided here due to general confusion concerning these services when they are purchased and then billed, rather than rendered and billed by the billing entity. As for any other services, suppliers must also meet current enrollment criteria as stated in *c*hapter 10 of the Program Integrity Manual in order to be able to enroll and bill for purchased tests and interpretations. That these services are purchased does not negate the need for appropriate enrollment procedures with the carrier that has jurisdiction over the geographic area where the services were rendered. Carriers must follow the instructions in §10.1.9 if they receive claims for services outside their jurisdiction.

Effective for claim processed on or after April 1, 2004, in order to allow the carrier to determine jurisdiction, price correctly, and apply the purchase price limitations, global billing will not be accepted for purchased services on electronic or paper claims. Claims received with global billings in this situation will be treated as unprocessable per §80.3.

A - Payment Jurisdiction for Suppliers of Diagnostic Tests for Purchased Interpretations

Per §30.2.9.1, suppliers *(including laboratories, physicians, and independent diagnostic testing facilities [IDTFs]) may receive payment for purchased interpretations. Effective for claims with dates of service on or after January 25, 2005, laboratories, physicians, and IDTFs must submit all claims for purchased interpretations to their local carrier.* Carriers must accept and process claims for purchased interpretations when billed by suppliers enrolled in the carrier's jurisdiction, regardless of the location where the service was furnished. Carriers should allow claims submitted by an IDTF for purchased interpretations if the IDTF has previously enrolled to bill for purchased diagnostic test components it performs.

B - Payment Jurisdiction for *Suppliers* for Purchased Diagnostic Tests

Per §30.2.9, suppliers (including laboratories, physicians, and IDTFs) may receive payment for purchased diagnostic tests. Effective for claims with dates of service on or after *January 25, 2005*, suppliers (including laboratories, physicians, and independent diagnostic testing facilities [IDTFs]) must submit all claims for purchased diagnostic tests to their local carrier. Carriers must accept and process claims for purchased diagnostic tests when billed by suppliers enrolled in the carrier's jurisdiction, regardless of the location where the service was furnished.

30.2.9 - Payment to Physician or Other Supplier for Purchased Diagnostic Tests - Claims Submitted to Carriers

(Rev. 464, Issued: 02-04-05, Effective: 04-01-05, Implementation: 04-04-05)

A physician or a medical group may submit the claim and (if assignment is accepted) receive the Part B payment, for the technical component of diagnostic tests which the physician or group purchases from an independent physician, medical group, or other supplier. (This claim and payment procedure does not extend to clinical diagnostic laboratory tests.) The purchasing physician or group may be the same physician or group as ordered the tests or may be a different physician or group. An example of the latter situation is when the attending physician orders radiology tests from a radiologist and the radiologist purchases the tests from an imaging center. The purchasing physician or group may not markup the charge for a test from the purchase price and must accept the lowest of the fee schedule amount if the supplier had billed directly; the physician's actual charge; or the supplier's net charge to the purchasing physician or group, as full payment for the test even if assignment is not accepted. (See section 10.1.1.2 for additional information on purchased diagnostic tests.)

In order to purchase a diagnostic test, the purchaser must perform the interpretation. The physician or other supplier that furnished the technical component must be enrolled in the Medicare program. No formal reassignment is necessary.

Effective for claims received on or after April 1, 2004:

- In order to have appropriate service facility location ZIP code and the purchase price of each test on the claim, when billing for purchased tests on the Form CMS-1500 paper claim form each test must be submitted on a separate claim form. Treat paper claims submitted with more than one purchased test as unprocessable per §80.3.2.

- More than one purchased test may be billed on the ANSI X12N 837 electronic format. When more than one test is billed, the total purchased service amount must be submitted for each service. Treat claims received with multiple purchased tests without line level total purchased service amount information as unprocessable per §80.3.2.

- Treat paper claims submitted for purchased services with both the interpretation and the purchased test on one claim as unprocessable per §80.3.2 unless the services are submitted with the same date of service and same place of service codes. When a claim is received that includes both services, and the date of service and place of service codes match, assume that the one address in Item 32 applies to both services. *Effective for claims with dates of service on or after April 1, 2005, each component of the test must be submitted on a separate claim form. Treat paper claims with dates of service after March 31, 2005 submitted with more than one purchased test as unprocessable per §80.3.2.*

- ANSI X12N 837 electronic claims submitted for purchased services with both the interpretation and purchased test on the same claim must be accepted. Assume that the claim level service facility location information applies to both services if line level information is not provided.

In order to price claims correctly and apply purchase price limitations, global billing is not acceptable for claims received on the Form CMS-1500 or on the ANSI X12N 837 electronic format. Each component must be billed as a separate line item (or on a separate claim per the limitations described above). Treat the claim as unprocessable per §80.3.2 when a global billing is received and there is information on the claim that indicates the test was purchased.

Effective for claims with dates of service on or after *January 25, 2005*, carriers must accept and process claims for purchased diagnostic tests when billed by suppliers (including laboratories, physicians, and independent diagnostic testing facilities [IDTFs]) enrolled in the carrier's jurisdiction, regardless of the location where the service was furnished. *Effective April 1, 2005, carriers must price purchased diagnostic test claims based on the ZIP code of the location where the service was rendered when billed by a laboratory or an IDTF,* using a CMS-supplied abstract file of the Medicare MPFS containing the HCPCS codes that are payable under the MPFS as either a purchased test or interpretation for the calendar year. (See IOM Publication 100-04, chapter 23, §30.6, and Addendum for record layouts and instructions for downloading the Abstract File for Purchased Diagnostic Tests/Interpretations.) *Until further notice, carriers must pay the local rate for purchased diagnostic test claims when submitted by a physician.*

NOTE: As with all services payable under the MPFS, the ZIP code is used to determine the appropriate payment locality and corresponding fee for the purchased test/interpretation. When a ZIP code crosses locality lines, CMS uses the dominant locality to determine the corresponding fee.

30.2.9.1 - Payment to Supplier of Diagnostic Tests for Purchased Interpretations

(Rev. 464, Issued: 02-04-05, Effective: 04-01-05, Implementation: 04-04-05)

A person or supplier that provides diagnostic tests may submit the claim, and (if assignment is accepted) receive the Part B payment, for diagnostic test interpretations which that person or entity purchases from an independent physician or medical group if:

- The tests are initiated by a physician or medical group which is independent of the person or entity providing the tests and of the physician or medical group providing the interpretations;

- The physician or medical group providing the interpretations does not see the patient; and

- The purchaser (or employee, partner, or owner of the purchaser) performs the technical component of the test. The interpreting physician must be enrolled in the Medicare program. No formal reassignment is necessary.

The purchaser must keep on file the name, the provider identification number and address of the interpreting physician. The rules permitting claims by a facility or clinic for services of an independent contractor physician on the physical premises of the facility or clinic are set forth in §§30.2.7 and 30.2.8.3.

NOTE: This change does not negate the requirement that when an entity either purchases an interpretation or a test, they themselves must perform the other component in order to be paid for the purchased component.

Effective for claims with dates of service on or after *January 25, 2005*, carriers must accept and process claims for purchased diagnostic interpretations billed by suppliers (including laboratories, physicians, and independent diagnostic testing facilities [IDTFs]) enrolled in the carrier's jurisdiction, for services furnished anywhere in the United States. *Effective April 1, 2005, carriers must price claims for purchased interpretations based on the ZIP code of the location where the service was rendered when submitted by a laboratory or IDTF,* using a CMS-supplied abstract file of the MPFS containing the HCPCS codes that are payable under the MPFS as either a purchased test or interpretation for the calendar year. (See IOM Publication 100-04, chapter 23, §30.6, and Addendum for record layouts and instructions for downloading the Abstract File for Purchased Diagnostic Tests/Interpretations.) *Until further notice, carriers must pay the local rate for purchased interpretation claims when submitted by a physician.*

NOTE: As with all services payable under the MPFS, the ZIP code is used to determine the appropriate payment locality and corresponding fee for the purchased test/interpretation. When a ZIP code crosses county lines, CMS uses the dominant locality to determine the corresponding fee.