



# Provider Inquiry Assistance

## Indicator for the Technical Component (TC) of Purchased Diagnostic Services – JA6122

Related CR Release Date : September 8, 2008

Date Job Aid Revised: September 15, 2008

Effective Date: December 8, 2008

Implementation Date: December 8, 2008

**Key Words** MM6122, CR6122, R1589CP, Technical, Component, Diagnostic, TC

**Contractors Affected**

- Part A/B Medicare Administrative Contractors (A/B MACs)
- Medicare Carriers

**Provider Types Affected**

Physicians and suppliers submitting claims to Medicare Carriers and/or A/B MACs for diagnostic services provided to Medicare beneficiaries



Change Request (CR) 6122 provides instructions to carriers or A/B MACs on how to process claims for diagnostic services when there is no entry for the "Yes/No" indicator in Block 20 of the Form CMS-1500, or if the claim does not contain either a claim or line level PS1 segment on the on the 837P X12 4010A1 electronic format to indicate whether the diagnostic services were purchased.

**Provider Needs to Know...**

- CR6122 instructs carriers and A/B MACs to assume that a diagnostic service is **not** purchased when there is no entry in either Block 20 on the Form CMS-1500, or there is no PS1 segment on the 837P X12 4010A1 electronic format.
- Carriers and AB MACs will adjudicate a claim lacking an entry for the "Yes/No" indicator or lacking the PS1 segment for a diagnostic service as if it were not a purchased service.
- Providers should note that if there is no indication that the service was purchased and the Centers for Medicare & Medicaid Services (CMS) later finds that the service had been purchased, this could result in finding of a false claim.
- In addition, a professional component (PC) service is not relevant for this policy. The purchase price of the PC portion is not, and should not be, a part of the adjudicative process of the TC.

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- Background**
- Medicare Carrier jurisdictional rules for purchased diagnostic tests/interpretations were changed in April 2005 to allow suppliers to bill their local carriers for diagnostic test/interpretation services (and receive the correct payment amount), regardless of the location where the services were performed.
  - Because all purchased diagnostic services are paid under the Medicare Physician Fee Schedule (MPFS), the diagnostic services are subject to the same payment rules as all other services paid under the MPFS, as well as to the jurisdictional rules for that fee schedule.
  - Only laboratories, physicians, and independent diagnostic testing facilities may bill for purchased tests and interpretations.
  - CMS has found that claims have been returned as unprocessable needlessly due to the fact that the biller did not indicate whether the TC of a diagnostic service had been purchased.
  - CMS has also found over time that if there was no indication in Block 20 on the Form CMS-1500 or claim or line level PS1 segment on the electronic claim, it was likely that the service had not been purchased.

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**Operational Impact**      N/A

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**Reference Materials**

The related MLN Matters article can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6122.pdf> on the CMS website.

The official instruction (CR6122) issued regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1589CP.pdf> on the CMS website.

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