

Frequently Asked Questions Related to Change Request 7631 (Revised and Clarified Place of Service Coding Instructions)

Change Request (CR) 7631 (Transmittal 2679) entitled “Revised and Clarified Place of Service (POS) Coding Instructions” became effective April 1, 2013. CR 7631 revised and clarified national policy for POS code assignment and clarified longstanding policy on reporting the service location for a given service code. Since publication, questions have been raised about the general Medicare requirements for billing the global diagnostic service code, the date of service, the POS for pathology and laboratory services, as well as enrollment, MAC jurisdiction and claims processing requirements. A compilation of the frequently asked questions (FAQs) about these issues and the CMS responses are provided below.

Q.1. When the professional component (PC) is performed in another State and the physician must enroll in that State:

A) How should the physician be credentialed?

CMS Response: The physician must be licensed in the state in which he or she is performing the service.

B) Is the CMS 855I used to obtain the individual PTAN?

CMS Response: Yes.

C) How does the physician present himself on the CMS 855I application?

CMS Response: The physician would specify his or her specialty on the application, just as he or she would with any other CMS-855I enrollment. We may need more clarification on this question, but the process for enrolling would not differ.

D) May “home” be used as a practice location on the application?

CMS Response: Yes, if that is where the service is being performed.

Q.2. If the technical component (TC) is furnished by an IDTF (Independent Diagnostic Treatment Facility) in a State which is different than the State in which the professional component (PC) is furnished:

A) What is the enrollment process for the individual physician who has reassigned benefits to the IDTF?

CMS Response: Currently, if the providers are located in different MAC jurisdictions, the enrollment requirements (and subsequent MAC jurisdiction) are determined by the specific Medicare claims processing

contractors involved. CMS is developing national enrollment requirements for situations where telehealth, teleradiology, and other services cross MAC jurisdictions.

B) When the CMS 855I is used to enroll an individual physician, how would the enrolled physician be linked to the IDTF for which services are provided, when there is no reassignment of benefits and a separate location (of the physician) cannot be added to the IDTF?

CMS Response: If the physician is not reassigning his or her benefits, there would be no linkage to the IDTF from an enrollment perspective. If the physician is ordering the IDTF imaging service, the IDTF would be required to identify the ordering physician's name and NPI on the claim.

C) IDTF claims use the NPI assigned to the facility. What NPI would the physician use on a professional component claim?

CMS Response: If the physician is billing for the professional component, he or she would use his or her own NPI.

D) Will the IDTF receive reimbursement for the professional component (PC) services?

CMS Response: If all reassignment and enrollment requirements are met, the IDTF may receive payment for the professional component services. Normal claims processing rules apply.

E) How do we indicate the reading location on the 855B, when no patients are seen at that location (for example, a home office)?

CMS Response: The reading location would be the location where the service was performed. So if it is done in a home office, that would be the practice location reported on the CMS-855.

F) What is the place of service (POS) for the professional component (PC) claim?

CMS Response: As a general policy, the POS for the PC of a diagnostic test (e.g. 71010 with modifier -26) shall be the setting in which the beneficiary received the technical component (TC) of the service. The POS code representing the setting where the beneficiary received the TC is entered in item 24B on the paper claim Form CMS 1500 (or its electronic equivalent).

When the beneficiary is a registered outpatient or an admitted inpatient, the POS code assignment shall be for that setting in which the beneficiary is receiving inpatient care or outpatient care, for example inpatient hospital (POS code 21) or outpatient hospital (POS 22). If the physician/practitioner is aware of the exact setting the beneficiary is a registered inpatient (or hospital outpatient), the appropriate inpatient POS code (or appropriate outpatient POS code) may be reported consistent with the code list annotated in Pub. 100-04, Medicare Claims Processing Manual, chapter 26, section 10.5.

In cases where it is unclear which POS code applies, the Medicare Part B claims processing contractor can provide guidance.

G) What date of service does the professional component (PC) claim use, the date of the test or the date of the interpretation?

CMS Response: CR 7631 entitled “Revised and Clarified Place of Service Coding Instructions” did not change any existing date of service reporting requirements. The date of service requirements are discussed in our Medicare Claims Processing Manual; Publication 100-04, Chapter 26, Section 10.4. The longstanding billing practice for reporting the date of service has remained unchanged.

Q.3.If the professional interpretation was furnished at an unusual and infrequent location for example a hotel or home, the payment locality is determined based on the Medicare enrolled location where the interpreting physician most commonly practices. What is the definition of infrequent?

CMS Response: In the context of billing separately for the professional interpretation of a diagnostic test, an infrequent location would refer to a specific location in which the furnishing of professional diagnostic test interpretations occurs rarely. In other words, the physician does not provide professional interpretations from the address including ZIP code in question on a consistent basis. If the radiologist frequently furnishes interpretation services from his or her home, the home may be an enrolled location under the Medicare program.

Q.4. Medicare’s claims instructions for “Item 32” state: Enter the name, address, and ZIP code of the facility if the services were furnished in a physician's office, hospital, clinic, laboratory, or facility other than the patient's home. Only one name, address, and ZIP code may be entered in the box. Please clarify which “name,” “address,” and “ZIP code” goes into Item 32.

Because every entity’s situation and organizational setup is unique, we strongly suggest that billing providers consult with their local Medicare

Administrative Contractor to get assistance with completing Item 32 based on their own individual situation. As promised, we are working with the MACs to ensure they understand and apply these policies appropriately.

To that extent, we are providing our contractors with the guideline below. Please use this as a tool for determining how Item 32 should be completed on your claims. We believe that most of the scenarios you present can be resolved by applying the following guideline for reporting the service location.

- **If the global diagnostic test code is billed, report the name, address and NPI of the location where the TC was furnished in Item 32 and 32a (or the 837P electronic claim equivalent). Note: Global billing is acceptable when both the TC and PC are performed by the same entity in the same MPFS payment locality.**
 - **If the TC and PC are billed separately, report the name, address and NPI of the location where each component was performed. If billing provider has an enrolled practice location at the address where the service was performed, the billing provider may report their own name, address and NPI in Item 32 and 32a. Whether the Group, individual physician, or IDTF is reported in Item 32 is dependent upon the billing provider's operational setup and is specific to each entity's own situation. Please consult your local Medicare Administrative Contractor for assistance with completing Item 32 based on specific operational arrangements. You may also refer Internet Only Manual, Pub. 100-04, Chapter 1, § 80.3.2.1.2 and 80.3.2.1.3 for more information regarding what is required in Item 32 and 32a.**
 - **If the service (such as the PC) was performed at an unusual or infrequently used location, the location of the provider's closest Medicare-enrolled practice location may be used in Item 32.**
 - **The NPI in Item 32a must correspond to the entity identified in Item 32 (no matter if it is the group, the hospital, the IDTF, or the individual physician). The only exception for Medicare claims is when a service is performed out of jurisdiction and is subject to anti-markup or is a reference lab service. (See Internet Only Manual, Pub. 100-04, Chapter 1, § 30.2.9 and Chapter 16, § 40.1 for instructions specific to anti-markup and reference lab, respectively)**
- a. *The technical component (TC) is performed at "Hospital A" and the rendering radiologist performs the interpretation (professional component) at "Hospital B."*
- *It is our understanding that if Hospital B is an enrolled practice location, then the Group Name and the enrolled location address*

(Hospital B) are entered in Box 32. Enter the Group's NPI in Box 32a if the carrier requires an NPI. (See question 2 below.)

CMS Response: See above.

- b. *The TC is performed at "Imaging Center 1" and the rendering radiologist performs the interpretation (professional component) at "Hospital B."*
- *Our understanding is if Hospital B is an enrolled practice location, then the Group Name and the enrolled location address (Hospital B) are entered in Box 32. Enter the Group's NPI in Box 32a if the carrier requires an NPI. (See question 2 below.)*

CMS Response: See above.

- c. *The TC is performed at "Hospital A" and the rendering radiologist performs the interpretation from his/her home."*
- *It is our understanding that if: (1) the radiologist's home is an infrequent location, then the Group Name and the common practice Medicare enrolled location are entered in Item 32 or (2) the radiologist's home is a Medicare enrolled location, then the Group Name and the radiologist's home address are entered in Item 32. Enter the Group's NPI in Box 32a if the carrier requires an NPI. (See question 2 below.)*

CMS Response: See above.

- d. *An order is generated for an imaging exam from a primary care physician's office and the TC is performed at "Hospital A" with the professional component (PC) performed at "Hospital B." When billing for a professional interpretation (PC), where on the claim form do you include the address of the technical exam (i.e., Hospital A)?*

It is our understanding there is no place on the claim form to identify the location of the exam's technical component (Hospital A).

CMS Response: Correct. Currently, when billing separately for the professional interpretation there is no place on the claim form to identify the location of the exam's technical component (Hospital A).

- e. *The hospital has an outpatient imaging center and it is: (1) located on the same contiguous campus as the main hospital or (2) located three blocks*

away from the main hospital. The radiology group provides interpretations for both locations (same campus).

- *It is our understanding that in Item 32, you would use the Group Name with the main hospital address when images are being interpreted at either location, as both are on the “same campus” and would enter the Group’s NPI in Box 32a if the carrier requires an NPI. (See question 2 below.)*

CMS Response: See above, however, we strongly recommend working with your local Medicare Administrative Contractor (MAC) and/or the hospital in which you are working to determine what is appropriate. The rules for determining what constitutes the hospital’s campus are dependent upon a number of factors (such as how the hospital is enrolled) and require consideration on a case by case basis.

Whether the service location is on the hospital’s campus or not becomes inconsequential if the Group has an enrolled practice location at the address where the service is being performed.

Q.5. Some Medicare Administrative Contractors (MACs) do not require Item 32a to be completed. Medicare’s claims instructions state “If required by Medicare claims processing policy, enter the NPI of the service facility.” Please clarify the NPI that should be used in the scenarios described above and for a teaching institution.

- *Our understanding is that the NPI in Item 32a should match that of the “Name” in Item 32.*

CMS Response: The NPI is required in Item 32a and must correspond to the entity identified in Item 32 (no matter if it is the group, the hospital, the IDTF, or the individual physician). The only exception for Medicare claims is when a service is performed out of jurisdiction and is subject to anti-markup or is a reference lab service. (See Internet Only Manual, Pub. 100-04, Chapter 1, § 30.2.9 and Chapter 16, § 40.1 for instructions specific to anti-markup and reference lab, respectively)

Q.6. Medicare permits global billing when the (TC) and the professional component (PC) are: (1) furnished by the same physician or provider entity and (2) furnished in the same Medicare physician fee schedule payment locality. Please clarify:

- a. *The required employment/contractual arrangements necessary for “same physician or supplier entity.” For example, can an entity bill globally (assuming the same locality rule is met) if it has: (1) an independent contractor relationship (1099) with its interpreting*

physician or (2) a contractual relationship with the physician's practice where the interpreting physician has individually joined the written agreement with the billing supplier entity?

- *It is our understanding that the "same supplier" entity means that the interpreting radiologist must have an owner/employee/independent contractor relationship, direct or indirect, (e.g., compensation is reported on a W2 or 1099) with the entity that provided the technical component or the interpreting physician must individually join the written agreement between the supplier entity and the physician's practice.*

CMS Response: Correct. As discussed in CR 7631 entitled "Revised and Clarified Place of Service (POS) Coding Instructions" effective April 1, 2013, the Medicare claims processing manual has been revised to specify when a global diagnostic service code may be billed. (Please see CR 7631 revision to the Medicare claims processing manual, Pub. 100-04, chapter 13 section 150 D.) Specifically, in order to bill for a global diagnostic service code, the same physician or supplier entity must furnish both the technical component of the test (TC) and the professional interpretation of the test (PC). Additionally, the professional interpretation and technical component must be furnished within the same physician fee schedule payment locality.

For purposes of billing a global diagnostic service code, services furnished by an employee of the supplier (including employees by contractual arrangement, for example a 1099 independent contractor) are considered furnished by the supplier if those services are provided within the scope of the employment.

In other words, by his or her employment with the supplier entity, the physician (or practitioner) that furnishes the professional interpretation of a diagnostic test is considered part of the same supplier entity that furnished the technical component of the diagnostic test. The size of the group with whom the 1099 relationship exists is not a distinguishing factor in defining "same supplier entity" for purposes of billing a global diagnostic service code. The important concept here is that the radiologist furnishing the professional interpretation must have an employment relationship with the supplier entity furnishing the technical component of the test.

Note that this clarification of "same supplier entity" as discussed in Pub. 100-04, chapter 13, section 150 D is for the sole purpose of determining when a global diagnostic service code may be billed and is not intended as a comment on any other aspect of the Medicare program.

- b. *Does the PC and TC have to be performed at the same location/facility or can the PC be performed remotely as long as it is within the same payment locality?*
- *It is our understanding that, as long as the arrangements meet the “same supplier” criteria describe above and both locations are in the same payment jurisdiction, the PC and TC can be performed at different locations yet still billed globally. Global billing is not possible if the TC and/or PC locations are in different payment localities or the parties do not meet the “same supplier” criteria.*

CMS Response: Correct. In order to bill for the global diagnostic service code, the same physician or supplier entity must furnish both the TC and PC and both the TC and PC must be furnished within the same Medicare physician fee schedule payment locality. The TC and PC may be furnished in different locations as long as they are furnished within the same MPFS payment locality, for example, if the TC is furnished in Douglas County Georgia and the PC is furnished in Fayette County Georgia, both the TC and the PC would be furnished in the same MPFS locality. Likewise, if the TC is furnished in the state of Kansas and the PC is furnished within the state of Kansas, then the PC and TC would be furnished in the same MPFS payment locality since all counties in the state of Kansas form a single “state wide” payment locality.

A listing of the current MPFS locality structure, including state, locality area (and when applicable, counties assigned to each locality area) may be accessed from <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html> on the CMS website. (Select “Medicare PFS Locality Configuration” from the menu on left.)

Q.7. Item 33 states “PHYSICIAN’S, SUPPLIER’S BILLING NAME, ADDRESS, and ZIP CODE & PHONE #.” Item 32 states “NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office).” Please clarify the differences between Item 33 and Item 32.

- *It is our understanding that billing information goes into Item 33 and Item 32 is for information about the provider who rendered/performed the service.*

CMS Response: Item 32 is used to identify the *location* where services were rendered so that the appropriate MPFS payment locality may be applied – not necessarily to identify the rendering/performing provider. Item 33 is used to identify the billing entity who is submitting the claim.

Q.8. If the TC and PC are furnished in different MAC jurisdictions and the PC is separately billed (no anti-markup and no reassignment) which MAC does the radiologist (interpreting physician) bill when submitting a claim for the professional component?

CMS response: When the TC and PC are furnished in different MAC jurisdictions (and the claim is not subject to anti-markup or reassignment) the interpreting physician should file the claim to his or her applicable Medicare claims processing contractor. For example, if the TC is furnished in Georgia and the PC is furnished in Florida, the interpreting physician (or his or her billing agent) should file the claim for the PC to the Florida MAC.

Q.9. What place of service code (POS) should be reported for laboratory and pathology services?

CMS Response: Clarification on the POS for pathology and laboratory services will be provided through another Change Request. Laboratories and pathologists should continue reporting the POS as they currently do (for example, as they would have prior to the effective date of CR 7631) until clarification is provided via another Change Request.