

MLN Matters Number: MM3551

Related Change Request (CR) #: 3551

Related CR Release Date: October 29, 2004

Effective Date: April 1, 2005

Related CR Transmittal #: 124

Implementation Date: April 4, 2005

## Common Working File (CWF) Duplicate Claim Edit for Referred Clinical Diagnostic Services and Purchased Diagnostic Services

**Note:** This article was updated on May 12, 2013, to reflect current Web addresses. All other information remains unchanged.

### Provider Types Affected

Physicians, laboratories, clinical laboratories, and independent diagnostic testing facilities (IDTFs)

### Provider Action Needed



#### STOP – Impact to You

Effective April 1, 2005, a new edit will be established in Medicare systems to check for duplicate claims for referred clinical diagnostic laboratory services and purchased diagnostic services submitted by physicians/suppliers to more than one carrier.

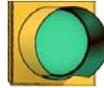


#### CAUTION – What You Need to Know

Claims submitted for referred clinical diagnostic/purchased diagnostic services will be identified as “duplicate claims” **when the involved claims contain different carrier numbers and all of the following data matches in the claim fields:** (a) Beneficiary Name; (b) Beneficiary Health Insurance Claim Number (HICN); (c) Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) code; (d) Date of Service; and (e) CPT/HCPCS Code Modifier.

#### Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.



### GO – What You Need to Do

Affected providers should be aware that a claim for a referred clinical diagnostic/purchased diagnostic service that is identified as a duplicate claim under the above criteria will be rejected.

## Background

---

The Center for Medicare & Medicare Services (CMS) recognizes that a clinical diagnostic laboratory may refer a specimen to another clinical diagnostic laboratory for testing. CMS generally requires the clinical diagnostic laboratory that furnishes the service to bill for the service. However, under certain conditions, §1833(h)(5)(A)(ii) of the Social Security Act permits a clinical diagnostic laboratory to bill for a clinical diagnostic laboratory fee-schedule service that was performed by another clinical diagnostic laboratory.

Prior to July 1, 2004, many carriers were unable to process a claim for a referred clinical diagnostic laboratory test when the test was performed outside of their jurisdiction because they did not possess that jurisdiction's fee schedule.

CMS had not previously required carriers to adjudicate a claim for a referred clinical diagnostic laboratory service furnished in another jurisdiction. Therefore, some carriers previously paid for referred clinical diagnostic services performed outside of their jurisdiction while others did not.

In addition, some carriers have permitted reference laboratories located outside of their jurisdiction to enroll by issuing "reference-use-only" Provider Identification Numbers (PINs) for the reference laboratories to use when billing for a referred clinical diagnostic service that was performed within their jurisdiction.

### *Implementation of National Clinical Laboratory Fee Schedule*

To resolve these issues, effective for claims with dates of service on or after July 1, 2004, CMS implemented a national clinical laboratory fee schedule and instructions to make fees for all localities within the United States available to their carriers for processing diagnostic laboratory claims, including claims for referred clinical diagnostic services performed outside of their jurisdiction.

Although CMS has issued billing guidelines for both referred clinical diagnostic laboratory services and for purchased diagnostic services, specifying that these services must be billed to the local carrier with the implementation of the respective fee schedules, either the physician/supplier performing the service, or the purchasing/referring physician/supplier (as applicable) may bill for the service.

To address a potential program vulnerability, effective April 1, 2005, CMS is implementing a new Common Working File (CWF) edit for both referred clinical diagnostic laboratory services and purchased diagnostic services to identify as

#### Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

duplicate claims those claims that are submitted for the same service, provided to the same beneficiary, and provided on the same date, when these claims are submitted to more than one carrier.

**Note:** Referred clinical laboratory services are identified for processing purposes by the presence of a "90" modifier. When performing the data matching, the CWF duplicate claim edit for referred clinical diagnostic/purchased diagnostic services will not include the "90" modifier on referred laboratory claims in the matching criteria, but will perform matching on all other criteria specified above.

The CWF duplicate claim edit will only apply to claims containing a CPT code that is included on the clinical laboratory fee schedule (available on the CMS clinical laboratory website at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html>), or a HCPCS code that is included on the Abstract File for Purchased Diagnostic Tests/Interpretations to be implemented in April 2005.

## Additional Information

---

The official instruction issued to your carrier regarding this change may be found by going to <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1240TN.pdf> on the CMS website.

If you have any questions regarding this issue, please contact your carrier at their toll free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

### Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.