

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1931	Date: March 12, 2010
	Change Request 6627

SUBJECT: Revision of the Internet Only Manual (IOM) to Remove References to “Purchased Diagnostic Test” and Replace With Language Consistent With the Anti-Markup Rule

I. SUMMARY OF CHANGES: Updates references to "purchased diagnostic tests;" replacing them with the new anti-markup language as finalized by the 2009 PFS final rule (73 FR 69799, November 19, 2008).

EFFECTIVE DATE: June 14, 2010

IMPLEMENTATION DATE: June 14, 2010

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	1/Table of Contents
R	1/10.1.1/Payment Jurisdiction Among Local B/MACs for Services Paid Under the Physician Fee Schedule and Anesthesia Services
R	1/10.1.1.2/Payment Jurisdiction for Services Subject to the Anti-Markup Rule
D	1/10.1.1.3/Payment Jurisdiction for Reassigned Services
R	1/30.2.1/Exceptions to Assignment of Provider’s Right to Payment - Claims Submitted to A/B MACs
R	1/30.2.2/Background and Purpose of Reassignment Rules - Claims Submitted to B/MACs
R	1/30.2.14/Correcting Unacceptable Payment Arrangements
R	1/30.3.7/Billing for Diagnostic Tests (Other Than Clinical Diagnostic Laboratory Tests) Subject to the Anti-Markup Payment Limitation - Claims Submitted to B/MACs
R	12/20.4/Summary of Adjustments to Fee Schedule Computations
D	13/20.2.4/Purchased Diagnostic Tests - Carriers

D	13/20.2.4.1/Carrier Payment Rules
D	13/20.2.4.2/Payment to Physician for Purchased Diagnostic Tests
N	13/20.3/Anti-Markup Payment Limitation
N	13/20.3.1/ B/MAC Payment Rules
N	13/20.3.2/Billing for Services
R	18/20.3/Payment
R	18/20.5/Billing Requirements - Carrier/B/MAC Claims
R	26/10.4/Items 14-33 - Provider of Service or Supplier Information
R	35/10.2/Claims Processing
R	35/30/Diagnostic Tests Subject to the Anti-Markup Payment Limitation

III. FUNDING:

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.

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

Pub. 100-04	Transmittal: 1931	Date: March 12, 2010	Change Request: 6627
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SUBJECT: Revision of the Internet Only Manual (IOM) to Remove References to “Purchased Diagnostic Test” and Replace With Language Consistent With the Anti-Markup Rule

EFFECTIVE DATE: June 14, 2010

IMPLEMENTATION DATE: June 14, 2010

I. GENERAL INFORMATION

A. Background: Section 1842(n)(1) of the Social Security Act limits payment for certain diagnostic tests where the physician performing or supervising the test does not share a practice with the billing physician or other supplier. Such a test was formerly referred to as a “purchased diagnostic test”. This statutory provision was codified in 42 CFR § 414.50. Prior to January 1, 2008, 42 CFR § 414.50 imposed an “anti-markup” payment limitation to the technical component (TC) of a diagnostic test (other than a clinical diagnostic laboratory test payable under the clinical laboratory fee schedule) that was billed by a physician or other supplier who purchase the test from an outside supplier.

In the CY 2008 Physician Fee Schedule (PFS) final rule (72 FR 66222, November 27, 2007), CMS amended the anti-markup provision in 42 CFR § 414.50 to expand the coverage of the anti-markup payment limitation to include situations where the TC is not performed in the “office of the billing physician or other supplier.” CMS also imposed an anti-markup payment limitation on the professional component (PC) of a diagnostic test ordered by a billing physician or other supplier if the PC is acquired by contractual arrangement or if the PC is not performed in the “office of the billing physician or other supplier.” However, in a subsequent final rule (73 FR 405, January 3, 2008), CMS delayed implementation of these new anti-markup provisions with the exception of certain provisions (see 42 CFR § 411.351).

Pub. 100-20, Transmittal 445, Change Request 6371, dated February 13, 2009, established claims processing instructions for diagnostic tests subject to the anti-markup payment limitation and the conditions under which the anti-markup provision applies. Transmittal 445, also indicated that the IOM would be updated at a later date to reflect the new anti-markup language.

The CY 2009 final rule (73 FR 69799, November 19, 2008) includes alternative methods for determining when the anti-markup payment limitation applies. Because this new application of the anti-markup rule is more complex than a simple contractual arrangement between two parties for a TC service, CMS is changing references to the term “purchased diagnostic test” in the IOM to reflect the new anti-markup language. CMS is not changing all of the references in the manual at one time, but will implement the changes over time beginning with this transmittal. To that end, changes to Pub. 100-04, Claims Processing Manual, chapter 1, §§30.2.9 - 30.2.9.1 and chapter 1, §80.3.2.1.2, will be manualized under separate transmittals. Until all changes are manualized, contractors shall read any reference of “purchased diagnostic test” as “anti-markup test”.

B. Policy: This transmittal updates the IOM to conform to the language of the revised regulation 42 CFR §414.50 and directs contractors to take note of the change in nomenclature. Contractors shall consider the term “purchased diagnostic test” to be obsolete. Contractors shall instead use the nomenclature associated with the new anti-markup rule and shall implement the use of the revised language in accordance with the instructions implemented by Transmittal 445 and as reflected in the manual changes presented herein.

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 I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
6627.1	Contractors shall refer to the updated manuals in the IOM which have been updated to reflect the new anti-markup language.	X			X						
6627.1.1	Contractors shall take note of the manual changes presented in Pub. 100-04, chapter 1, §§10.1.1, 10.1.1.2, 30.2.1, 30.2.2, 30.2.14, and 30.3.7.	X			X						
6627.1.2	Contractors shall take note of the manual changes presented in Pub. 100-04, chapter 12, §20.4.	X			X						
6627.1.3	Contractors shall take note of the manual changes presented in Pub. 100-04, chapter 13, §§20.3, 20.3.1, and 20.3.2.	X			X						
6627.1.4	Contractors shall take note of the manual changes presented in Pub. 100-04, chapter 18, §§20.3 and 20.5.	X			X						
6627.1.5	Contractors shall take note of the manual changes presented in Pub. 100-04, chapter 26, §10.4.	X			X						
6627.1.6	Contractors shall take note of the manual changes presented in Pub. 100-04, chapter 35, §§10.2 and 30.	X			X						
6627.1.7	Contractors shall take note of the manual changes presented in Pub. 100-08, chapter 10, §4.19.3.	X			X						
6627.1.8	Contractors shall take note of the manual changes presented in Pub. 100-08, chapter 14, §14.5.	X			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	
6627.2	<p>A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv.</p> <p>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 shall be included in your next regularly</p>	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 H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.										

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:
6627.3	Until all changes are manualized, contractors should read any references to "purchased diagnostic tests" as "anti-markup test."
6627.4	Transmittal 445, CR 6371, dated February 13, 2009.

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

V. CONTACTS

Pre-Implementation Contact(s): Felicia Rowe, felicia.rowe@cms.hhs.gov or by phone at (410) 786-5655.

Post-Implementation Contact(s): For issues related to claims processing, contact Felicia Rowe at felicia.rowe@cms.hhs.gov or by phone at (410) 786-5655. For issues related to the anti-markup payment limitation, contact Dave Walczak at david.walczak@cms.hhs.gov or by phone at (410)786-4475.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs)*, *Regional Home Health Intermediaries (RHHIs)*, and/or *Carriers*, use only one of the following statements:

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)*, include the following statement:

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

Table of Contents (Rev.1931, 03-12-10)

10.1.1 - Payment Jurisdiction Among *Local B/MACs* for Services Paid Under the Physician Fee Schedule and Anesthesia Services

10.1.1.2 - Payment Jurisdiction for *Services Subject to the Anti-Markup Payment Limitation*

30.2.1 - Exceptions to Assignment of Provider's Right to Payment - Claims Submitted to *A/B MACs*

30.2.2 - Background and Purpose of Reassignment Rules - Claims Submitted to *B/MACs*

30.3.7 - Billing for Diagnostic Tests (Other Than Clinical Diagnostic Laboratory Tests) *Subject to the Anti-Markup Payment Limitation* - Claims Submitted to *B/MACs*

10.1.1 - Payment Jurisdiction Among *Local B/MACs* for Services Paid Under the Physician Fee Schedule and Anesthesia Services

(Rev.1931, Issued: 03-12-10, Effective: 06-14-10, Implementation: 06-14-10)

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, *B/MACs* must use the ZIP code of the location where the service was rendered to determine *B/MAC* 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,” if they are not already doing so, *B/MACs* 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 section 10.1.1.1 for instructions on 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 *B/MAC's* service area (e.g., provider has separate offices in multiple localities and/or multiple *B/MACs*), separate claims must be submitted to the appropriate area *B/MACs* 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 *B/MAC's* service area (e.g., Indiana), the *B/MAC* which processes claims for the payment locality where the out of office service was furnished has jurisdiction for that service. It is the *B/MAC* 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 *B/MAC* 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 *B/MAC* for *the technical component (TC) and professional component (PC) of diagnostic tests that are subject to the anti-markup payment limitation*, regardless of the location where the service was furnished. Beginning in 2005, and in each subsequent calendar year (CY) thereafter, CMS will provide *B/MACs* with a national abstract file containing Healthcare Common Procedural Coding System (HCPCS) codes that are payable under the MPFS as *anti-markup tests* 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 MFSDDB 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 *of this chapter* for *information on the anti-markup payment limitation as it applies to* supplier billing requirements.

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 *B/MAC* 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 *B/MAC* 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-*contractor* state fails to specify the location where an office-based service was furnished, the *B/MAC* 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 *B/MAC* for processing. However, the specific location where the services were furnished must be entered on the claim so the *B/MAC* 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. *B/MACs* 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. *B/MACs* shall take this same action for any other POS codes they currently treat as POS home.

C. Outside *B/MAC* Jurisdiction

If *B/MACs* 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, *B/MACs* 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 *B/MACs*, 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 *Services Subject to the Anti-Markup Payment Limitation*

(Rev.1931, Issued: 03-12-10, Effective: 06-14-10, Implementation: 06-14-10)

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 *performed or supervised by a physician or other supplier who does not meet the criteria for “sharing a practice” with the billing physician or other supplier*, rather than rendered and billed by the billing entity. *(See §30.2.9 for additional information on “sharing a practice.”)* *Physicians and other suppliers must meet the current enrollment criteria stated in chapter 10, of the Program Integrity Manual, in order to be able to bill for anti-markup tests.* That these services are *billed by an entity that does not share a practice with the performing physician or other supplier* does not negate the need for *the performing physician or other supplier to follow* appropriate enrollment procedures with the *B/MAC* that has jurisdiction over the geographic area where the services were rendered.

The B/MACs must accept and process claims for services subject to the anti-markup payment limitation when billed by physicians or other suppliers enrolled in the B/MAC’s jurisdiction, regardless of the location where the services were furnished. In this instance, the billing entity must submit its own NPI with the name, address, and ZIP code of the performing physician or other supplier in the appropriate data field. The billing physician or other supplier should maintain a record of the performing physician or other supplier’s NPI in the clinical record for auditing purposes.

Effective for claims processed on or after April 1, 2004, in order to allow the *B/MAC* to determine jurisdiction and apply the *anti-markup payment limitation correctly*, global billing will not be accepted on electronic or paper claims *when billing anti-markup tests*. Claims received with global billings in this situation will be treated as unprocessable per §80.3.

A. Payment Jurisdiction for *Suppliers of Diagnostic Tests and Interpretations Performed by Other Suppliers under Contract*

Effective for claims with dates of service on or after January 25, 2005, laboratories, physicians, and IDTFs must submit all claims for *anti-markup tests* to their local *B/MAC*. *B/MACs* must accept and process claims for *services subject to the anti-markup payment limitation* when billed by suppliers enrolled in the *B/MAC’s* jurisdiction, regardless of the location where the services were furnished. *B/MACs* should allow claims submitted by an IDTF for *anti-markup tests* if the IDTF has previously enrolled to bill for *anti-markup test components they perform*.

Effective April 1, 2005, B/MACs must price anti-markup tests billed by laboratories and IDTF’s based on the ZIP code of the location where the diagnostic test was rendered.

Effective for claims with dates of service on or after October 1, 2007, B/MACs must use the national abstract file to price all claims for anti-markup tests for all supplier specialty types (including physicians), based on the ZIP code of the location where the service was rendered.

B. Payment Jurisdiction for Reassigned Services

Anti-markup tests payable under the MPFS that have been reassigned are subject to the anti-markup payment limitation. Though a supplier or provider may reassign payment for his services to another entity, suppliers are still required to bill the correct B/MAC for reassigned services when they are paid under the MPFS. The billing entity must submit claims to the B/MAC that has jurisdiction over the billing entity's own geographical area. B/MACs are required to accept and process these claims; referring to the fee schedule that applies to the appropriate jurisdiction where the service was performed in order to determine the payment amount. Suppliers and providers must also meet the current enrollment criteria stated in chapter 10 of the Program Integrity Manual in order to be able to bill for reassigned services.

30.2.1 - Exceptions to Assignment of Provider's Right to Payment – Claims Submitted to *A/B MACs*

(Rev.1931, Issued: 03-12-10, Effective: 06-14-10, Implementation: 06-14-10)

A. Payment to Government Agency

Medicare payment for the services of a provider is not made to a governmental agency or entity except when payment to the governmental agency or entity is permissible under the other listed reassignment exceptions, e.g., where the agency is the employer of the physician.

B. Payment Pursuant to Court Order

The Medicare program may make payment in accordance with an assignment established by, or pursuant to the order of, a court of competent jurisdiction. The assignment must satisfy the conditions set forth in §30.2.

C. Payment to Agent

The Medicare program may make payment, in the name of the provider, to an agent who furnishes billing or collection services. The payment arrangement must satisfy the conditions in §30.2.4.

D. Payment to Employer

The *B/MAC* may pay the employer of the physician or other supplier if the physician or other supplier is required, as a condition of his employment, to turn over to his employer the fees for his services. (See §30.2.6.)

E. Payment for Services Provided Under a Contractual Arrangement

The *B/MAC* may make payment to an entity enrolled in the Medicare program for services provided by a physician or other person under a contractual arrangement with that entity. The services may be furnished on or off the premises of the entity submitting the claim. Both, the entity submitting the claim and receiving payment and the physician or other person under contract are subject to certain program integrity requirements. (See §30.2.7.)

F. Payment for *Anti-Markup Tests*

The *B/MAC* may pay a physician (or a physician's medical group) *or other supplier* for *the TC or PC of* diagnostic tests (other than clinical diagnostic laboratory tests) that *the physician or other supplier contracts* an independent physician, medical group, or other supplier *to perform*. *The anti-markup payment limitation applies when the performing physician or other supplier does not meet the criteria for sharing a practice with the billing physician or other supplier. The contracting physician, physician's group, or other supplier must accept as payment in full the lower of: (a) the acquisition price; (b) the submitted charge for the service; or (c) the fee schedule amount. (See §30.2.9, of this chapter, for additional information on the anti-markup payment limitation.)*

G. Payment Under Reciprocal Billing Arrangements

The *B/MAC* may pay the patient's regular physician for services provided to his/her patients by another physician on an occasional reciprocal basis. (See §30.2.10.)

H. Payment Under Locum Tenens Arrangements

The *B/MAC* may pay the patient's regular physician for services of a locum tenens physician during the absence of the regular physician where the regular physician pays the locum tenens on a per diem or similar fee-for-time basis, and certain other requirements are met. (See §30.2.11.)

30.2.2 - Background and Purpose of Reassignment Rules - Claims Submitted to *B/MACs*

(Rev.1931, Issued: 03-12-10, Effective: 06-14-10, Implementation: 06-14-10)

In 1972, Congress acted to stop a practice under which some physicians and other suppliers providing covered services reassigned their Medicare and Medicaid receivables to other organizations and groups, which then claimed and received payment. Often the organizations *acquired* the claims at a percentage of face value. It had become apparent that such reassignments were a source of incorrect, inflated, and even fraudulent Medicare and Medicaid claims. The Social Security Act Amendments of 1972, Public Law 92-603, enacted a prohibition against payment on a charge basis for covered services to anyone other than the patient, physician or other person who provided the service, with limited exceptions.

Thereafter, some physicians and other suppliers circumvented the intent of the law by granting a power of attorney. This allowed the factoring company or other person to receive the Medicare or Medicaid payments in the name of the physician or other supplier, thus permitting continuation of program abuses.

Section 2(a) of Public Law 95-142, dated October 25, 1977, modified existing law to preclude the use of power of attorney as a device for reassignment of benefits under Medicare, subject to limited exceptions. It also provides for a similar prohibition with respect to payment for care furnished by providers.

These provisions preclude Medicare payment of amounts due a provider or other person to a person or entity furnishing financing to the provider, whether the provider sells the provider's claims to that person or entity or pledges them to that person or entity as collateral on a loan.

A. Who is Supplier of Services

The question of reassignment arises only when assigned payment is made to someone other than the physician or other practitioner or supplier that furnished the services.

A supplier may be an individual, partnership, corporation, trust, or estate. Any services furnished by an employee of the supplier are considered furnished by the supplier if those services are within the scope of the employment. Where the supplier is a partnership, any services furnished by a partner are considered furnished by the supplier if those services are

within the scope of the partnership agreement. Therefore, issues of reassignment are limited to claims submitted to *B/MACs*.

Services that one physician or other supplier purchases from another are not usually considered furnished by the purchasing supplier for purposes of the prohibition on reassignment.

When one supplier purchases or rents items (as distinguished from services) from another supplier and resells or re-rents those items to the beneficiary, no reassignment issue arises. The supplier that sells or rents the items to the beneficiary is considered to furnish them.

In the case of drugs used in conjunction with durable medical equipment (DME) or prosthetic devices, the entity that dispenses the drug must furnish it directly to the patient for whom a prescription is written. Therefore, those drugs cannot be purchased for resale to the beneficiary by any supplier that is not the entity that dispenses the drugs. Such a supplier may only bill for the DME or prosthetic devices. In order for prescription drugs that are used in conjunction with DME or prosthetic devices to be covered by Medicare, the entity that dispenses the drugs must have a Medicare supplier number, must be licensed to dispense the drug in the State in which the drug is dispensed, and must bill and receive payment in its own name.

B. Effect of Payment to Ineligible Recipient

An otherwise correct Medicare payment made to an ineligible recipient under a reassignment or other authorization by the physician or other supplier does not constitute a program overpayment. Sanctions may be invoked under §30.2.15 against a physician or other supplier to prevent him from executing or continuing in effect such an authorization in the future, but neither the physician nor other supplier nor the ineligible recipient is required to repay the Medicare payment. See chapter 10 of the Medicare Program Integrity Manual for appeal rights of physicians and physician groups when billing numbers are revoked for non-compliance with the reassignment rules. Appeal rights for prospective and existing providers can be found at 42 CFR §498 of the Medicare regulations.

C. Effect of Reassignment on Assignment Agreement

An assignment is an agreement between a physician (or other supplier of services) and an enrollee where the enrollee transfers to the physician his/her right to benefits based on covered services specified on the assigned claim. The physician in return agrees to accept the approved charge determination by the *B/MAC* as his/her full charge for the items or services. In effect, the physician who accepts assignment is precluded from charging the enrollee more than the deductible and coinsurance based upon the approved charge determination.

When a qualified entity accepts assignment for a service furnished by a physician (thereby agreeing to collect no more than the Medicare deductible and coinsurance based on the allowed amount from the beneficiary), it is the entity and not the physician that is *bound* by the terms of the assignment. In this situation, the physician may accept from the entity a set fee or other payment that is greater than the reasonable charge, without violating the terms of the assignment. If the entity pays the physician such amount, the entity must absorb any loss resulting from the excess of the payment to the physician over the reasonable charge. An entity may accept assignment for a physician's services only if the employment or other contractual arrangement

between the entity and the physician provides that it alone has the right to bill and receive the payment for the services. The beneficiary is fully protected against any liability for the difference between the reasonable charge and any higher fee owed by the entity to the physician, since only the entity may collect from the beneficiary, and then only in the amount of the applicable deductible and coinsurance.

When a physician or *non-physician* practitioner opts out of the Medicare program and is a member of a group practice or otherwise reassigns his or her right to bill and receive Medicare payment to an organization, the organization may no longer bill Medicare or receive Medicare payment for the services that the *opt out* physician or *non-physician* practitioner furnishes to Medicare beneficiaries. However, if the *opt out* physician or *non-physician* practitioner continues to grant the organization with the right to bill and receive payment for the services he or she furnishes to patients, the organization may bill and be paid by the beneficiary for the services that are provided under the private contract. In addition, the decision of a physician or *non-physician* practitioner to opt out of Medicare does not affect the ability of the group practice or organization to bill Medicare for the services of physicians and/or *non-physician* practitioners who have not opted out of Medicare.

Suppliers not enrolled in Medicare may not receive payment.

30.2.14 - Correcting Unacceptable Payment Arrangements *(Rev.1931, Issued: 03-12-10, Effective: 06-14-10, Implementation: 06-14-10)*

A. Disseminating Information

From time to time, *A/B MACs* must disseminate through professional relations media information regarding the prohibition in §30.2.

A/MACs

The following language may be used by *A/MACs* or adapted for this purpose:
The Medicare law prohibits us from paying benefits due a provider to another person or organization under an assignment, power of attorney, or any other arrangement whereby that other person or organization receives those payments directly. There are the following exceptions to this rule:

- CMS may pay a provider's benefits (in the provider's name) to a billing or collection agent, if:
 - o The agent receives the payment under an agency agreement with the provider;
 - o The agent's compensation is not related in any way to the dollar amounts billed or collected;
 - o The agent's compensation is not dependent upon the actual collection of payment;
 - o The agent acts under instructions which the provider may modify or revoke at any time; and
 - o The agent, in receiving payment, acts only in the providers' behalf.
- CMS may pay the providers' benefits in accordance with an assignment established by, or pursuant to the order of, a court of competent jurisdiction.

A provider should notify us immediately if:

- CMS has been mailing its benefits to the address of another person or organization;
- The provider has given that other person or organization power of attorney or other advance authority to negotiate its benefit checks; and
- None of the above exceptions that would permit payment to another person or organization apply in the provider's case.

A provider which hereafter enters into or continues such a prohibited payment arrangement may have its participation in the program terminated and its right to receive assigned payment for physician services revoked.

B/DME MACs

A *B/DME MAC* may use or adapt the following language for notification:

The Medicare law prohibits us from paying benefits due a physician or other supplier of health care items and services, to another person or organization, under a reassignment or power of attorney or under any other arrangement whereby that other person or organization receives those payments directly. There are the following exceptions to this rule:

- CMS may pay a physician's or supplier's employer under the terms of his/her employment.
- CMS may pay a hospital, clinic, or other facility for services furnished by the physician or supplier in the facility, in accordance with the physician's or supplier's agreement with the facility.
- CMS may pay a group practice prepayment plan, prepaid health plan, or
- HMO for services of physicians and suppliers associated with the plan.
- CMS may pay a physician, medical group, *or other supplier* for *the technical component (TC) or professional component (PC) of diagnostic tests (other than clinical diagnostic tests) that are subject to the anti-markup payment limitation.*
- CMS may pay the patient's regular physician for services provided to his/her patients by another physician on an occasional, reciprocal basis
- At least until December 31, 1993, CMS may pay the patient's regular physician for services of a locum tenens physician during the absence of the regular physician where the regular physician pays the locum tenens on a per diem or similar fee-for-time basis.
- CMS may pay a physician's or supplier's benefits in his/her name to a billing or collection agent, e.g., a medical bureau, if:
 - o The agent receives the payment under an agency agreement with the physician or supplier;
 - o The agent's compensation is not related in any way to the dollar amounts billed or collected;
 - o The agent's compensation is not dependent upon the actual collection of payment;
 - o The agent acts under instructions which the physician or supplier may modify or revoke at any time; and
 - o The agent, in receiving the payment, acts only on the physician's or supplier's behalf.
- CMS may pay a physician's or supplier's benefits in accordance with a reassignment established by, or pursuant to the order of, a court of competent jurisdiction.

A physician or supplier should notify us immediately if:

- CMS has been mailing his/her benefits to the address of another person or organization;
- The physician has given that other person or organization power of attorney or other advance authority to negotiate the physician's benefit checks; and
- None of the above exceptions which would permit payment to another person or organization apply in his/her case.

A physician or other eligible recipient of assigned payment who hereafter enters into or continues such a prohibited payment arrangement may have the right to receive assigned payment revoked.

30.3.7 - Billing for Diagnostic Tests (Other Than Clinical Diagnostic Laboratory Tests) *Subject to the Anti-Markup Payment Limitation - Claims Submitted to B/MACs*

(Rev.1931, Issued: 03-12-10, Effective: 06-14-10, Implementation: 06-14-10)

A. General

A physician or other supplier may bill and receive payment for the technical component (TC) or professional component (PC) of a diagnostic test (other than clinical diagnostic laboratory test) that is performed by a physician or other supplier with whom the billing physician or other supplier does not share a practice. Reimbursement for that service is subject to the anti-markup payment limitation. If a physician or other supplier's bill or a request for payment includes a charge for a diagnostic test (other than a clinical diagnostic laboratory test) which the physician or other supplier did not personally perform or supervise, then payment for the test may not exceed the lesser of:

- *The performing physician's net charge to the billing physician or other supplier (net any discounts);*
- *The billing physician's actual charge; or*
- *The fee schedule amount that would be allowed for the test if the performing physician or other supplier billed directly.*

(See §30.2.9 of this chapter for additional information.)

For payment to be made, the physician who *acquires the TC or PC of a diagnostic test* from an outside source must identify the *performing physician or other supplier in Item 32 of the CMS-1500 claim form (or electronic equivalent) by supplying their name, address, and NPI. If the performing physician provides the service outside the B/MAC jurisdiction where the billing physician is located, the billing physician must submit its own NPI with the name, address, and ZIP code of the performing physician or other supplier in the appropriate data field. (The billing physician or other supplier should maintain a record of the performing physician or other supplier's NPI in the clinical record for auditing purposes.) The billing physician or other supplier must also indicate in Item 20 of the CMS-1500 (or corresponding loop and segment on the ANSI X12N 837) that the test is subject to the anti-markup payment limitation by checking "Yes" and entering the amount the performing physician or other supplier charged. No payment may be made to the physician without this information unless the statement "No anti-markup tests are included" is annotated on the claim.*

NOTE: *If the billing physician performs only the TC or the PC and wants to bill for both components of the diagnostic test, the TC and PC must be reported as separate line items if billing electronically (ANSI X12 837) or on separate claims if billing on paper (CMS-1500). Global billing is not allowed unless the billing physician or other supplier performs both components.*

B. Unassigned Claims with Required Documentation

A physician *or other supplier* may not bill an individual an amount in excess of Medicare's payment, except for any deductible and coinsurance, for *the TC or PC of a diagnostic test that is subject to the anti-markup payment limitation*. B/MACs must notify physicians *and other suppliers that they must* indicate when a diagnostic test was *acquired*, identify the *performing physician or other* supplier, and show the amount the *performing physician or other* supplier charged. The notification must inform *physician and other suppliers* that they are prohibited by §1842(n)(3) of the Act from billing or collecting an amount in excess of Medicare's payment, except for the deductible and coinsurance. Excess amounts collected from the beneficiary must be repaid.

C. Unassigned Claims without Required Documentation

A physician may not bill a beneficiary:

- If the bill does not indicate who performed the test; and
- If the bill indicates that a *separate physician or other supplier* performed the test, it does not identify the *performing physician or other supplier* or does not include the amount *the performing physician or other supplier* charged.

The B/MACs notify the physician when a non-assigned claim for *the TC or PC of a diagnostic test subject to the anti-markup payment limitation* is received from either the physician or a beneficiary except when the physician submits an assigned claim and the beneficiary submits an unassigned duplicate claim. They use the following sample letter.

Dear Doctor:

We have received an unassigned claim for diagnostic tests furnished to the patient (Beneficiary Name), on (Date of Service). You are prohibited by §1842(n)(3) of the Social Security Act from billing or collecting any amount unless you indicate that "No *anti-markup tests* are included" or, if the diagnostic test was *acquired*, you indicate who performed the test and what the *physician or other* supplier charged you. Some or all of the required information is missing from your patient's claim. If you have collected any amount from your patient, it must be refunded. This claim may be resubmitted if the required information is included.

D. Beneficiary Information Regarding Unassigned Claims

The B/MACs must notify the beneficiary that the physician is prohibited from:

- Billing the beneficiary when the necessary documentation is not supplied; and
 - Billing or collecting an amount in excess of Medicare's payment, except for the deductible and coinsurance, when the required documentation is submitted.
- (See chapter 21, for MSN messages.)

20.4 - Summary of Adjustments to Fee Schedule Computations *(Rev.1931, Issued: 03-12-10, Effective: 06-14-10, Implementation: 06-14-10)*

For services prior to January 1, 1994, *B/MACs* computed the fee schedule amount for every service. Through 1995, the fee schedule amount is the transition fee schedule amount. For services after 1995, CMS computes and provides the fee schedule amount for every service discussed above.

Certain adjustments are made in order to arrive at the final fee schedule amount. Those adjustments are:

- Participating versus nonparticipating differential;
- Reduction for re-operations;
- Site of service payment adjustment;
- Multiple surgeries;
- Bilateral surgery;
- *Anti-Markup Payment Limitation*;
- Provider providing less than global fee package;
- Assistant at surgery;
- Two surgeons/surgical team; and
- Supplies.

Medicare Claims Processing Manual

Chapter 13 - Radiology Services and Other Diagnostic Procedures

Table of Contents *(Rev.1931, 03-12-10)*

20.3 – Anti-Markup Payment Limitation

20.3.1 – B/MAC Payment Rules

20.3.2 - Billing for Services

20.3 – Anti-Markup Payment Limitation

(Rev.1931, Issued: 03-12-10, Effective: 06-14-10, Implementation: 06-14-10)

Section 1842(n)(1) of the Social Security Act (the Act) establishes payment rules for *certain* diagnostic tests (*other than clinical diagnostic laboratory tests*) where the physician performing or supervising the test does not share a practice with the billing physician or other supplier. *Examples of tests covered under this rule* include, but are not limited to: x-rays, EKGs, EEGs, cardiac monitoring, *and* ultrasound services furnished on or after January 1, 1994. (Note that screening mammography services are covered under another provision of the Act and are not subject to the *anti-markup payment* limitation.) *The anti-markup payment limitation applies to the technical component or “TC” of certain diagnostic tests that are payable on the Medicare Physician Fee Schedule (MPFS). Effective January 1, 2009, the anti-markup payment limitation also applies to the professional component or (“PC”) of diagnostic tests (other than clinical diagnostic tests). The anti-markup payment limitation only applies when a physician (or other supplier) orders and bills for a diagnostic test in which the TC or PC is performed by a physician who does not “share a practice” with the ordering/billing physician (or other supplier). For more information on the anti-markup payment limitation, see chapter 1, §30.2.9.*

20.3.1 – B/MAC Payment Rules

(Rev.1931, Issued: 03-12-10, Effective: 06-14-10, Implementation: 06-14-10)

If a *diagnostic* test (*other than a clinical diagnostic laboratory test*) is personally performed or is supervised by a physician, such physician may bill under the normal physician fee schedule rules. This includes situations in which the test is performed or supervised by another physician with whom the billing physician shares a practice (*See Pub. 100-04, chapter 1, §30.2.9*). Section 80, chapter 15, of Pub. 100-02, Medicare Benefit Policy, sets forth the various levels of physician supervision required for diagnostic tests. The supervision requirement for physician billing is not met when the test is administered by supplier personnel regardless of whether the test is performed at the physician's office or at another location.

If a physician bills for a diagnostic test *that is subject to the anti-markup payment limitation*, the fee schedule amount for the *acquired* service equals the lower of:

- *The performing physician or other supplier’s net charge to the billing physician or other supplier for performing the service;*
- *The billing physician or other supplier’s actual charge; or*
- *The fee schedule amount allowed for the jurisdiction where the service was performed.*

The *lowest* figure is the fee schedule amount for purposes of the limiting charge. (See *chapter 1, §30.3.12.1* of this publication) The billing *entity* must identify the *performing physician or other supplier* (including the *performing provider’s NPI*) and the amount the *performing physician or other supplier* charged the billing *entity* (net of any discounts). A physician who accepts assignment is permitted to bill and collect from the beneficiary only the applicable deductible and coinsurance for the *acquired* test. A physician who does not accept assignment is permitted

to bill and collect from the beneficiary only the fee schedule amount (as defined above) for the *acquired* test. The limiting charge provision is not applicable.

If the physician does not identify *who performed the test* and provide the other required information, no payment is allowed. *The physician may not bill the beneficiary any amount for the test.*

20.3.2 - Billing for Services

(Rev.1931, Issued: 03-12-10, Effective: 06-14-10, Implementation: 06-14-10)

A physician or *other supplier* may *bill* and receive Part B payment for the technical component (*TC*) or *professional component (PC)* of diagnostic tests which the physician or *other supplier contracts* a physician, medical group, or other supplier *to perform*. (This claim and payment procedure does not extend to clinical diagnostic laboratory tests.) *The anti-markup rule will apply to the TC or PC of diagnostic tests that have been ordered by the billing physician or other supplier (or by a party financially related to the billing physician or other supplier through common ownership or control) if the performing physician or other supplier does not meet the criteria for “sharing a practice” with the ordering/billing entity.* An example is when the attending physician orders radiology tests from a radiologist and the radiologist purchases the tests from an imaging center *with whom the radiologist does not meet the criteria for “sharing a practice.”* *Under the anti-markup payment limitation, the billing physician or other supplier may not mark up the charge for a test from the acquisition price and must accept as full payment for the test (even if assignment is not accepted) the lowest of: the fee schedule amount as if the performing physician or other supplier had billed directly, the billing entity’s actual charge, or the performing physician or other supplier’s net charge to the billing entity.* The *billing physician or other supplier must be financially related to the physician or group that ordered the tests through common ownership or control.*

If the performing physician or other supplier meets the criteria for “sharing a practice” with the billing physician or other supplier, then the anti-markup payment limitation will not apply and the lower of the physician fee schedule amount or the billed amount will be paid.

The physician or other supplier that *performed the component that is subject to the anti-markup rule* must be enrolled in the Medicare program. No formal reassignment is necessary; *however, reassigned services are also subject to the anti-markup payment limitation.*

A. Radiology Services

Contractors shall apply the anti-markup payment limitation to the TC and PC of radiology diagnostic testing services other than screening mammography procedures. See Publication 100-04, chapter 1, §30.2.9 for more information on the anti-markup payment limitation.

B. Payment to a Physician or Other Supplier of Diagnostic Tests for Services Subject to the Anti-Markup Payment Limitation

A *physician or other supplier* that provides diagnostic tests may *bill and* receive the Part B payment for *the TC or PC of diagnostic tests* which that *physician or other supplier acquires*

from another physician, medical group, or other supplier. If the performing physician does not meet the requirements for sharing a practice with the ordering/billing physician or other supplier, then the anti-markup payment limitation rules will apply. (See section 30.2.9 of this chapter for more information.) If the performing physician is deemed to share a practice with the physician or other supplier that ordered the test, then the physician fee schedule amount may be billed and the anti-markup payment limitation will not apply. In either case, the performing physician or other supplier must be enrolled in the Medicare program. No formal reassignment is necessary; however, the anti-markup payment limitation will apply to reassigned services.

If the anti-markup rules apply, payment may not exceed the lowest of the following amounts:

- The performing physician or other supplier's net charge to the billing physician or other supplier;**
- The billing physician or other supplier's actual charges; or*
- The fee schedule amount allowed for the test if the performing physician or other supplier billed directly.*

**The net charge must be determined without regard to any charge that is intended to reflect the cost of equipment or space leased to the performing physician or supplier by or through the billing entity. For more information, see Pub. 100-04, chapter 1, §30.2.9.*

The *billing physician or other supplier* must keep on file the name, address, *and NPI* of the *physician or other supplier who performed the anti-markup service.*

C. Sanctions

Physicians who knowingly and willfully, in repeated cases, bill Medicare beneficiaries amounts beyond those outlined in this chapter are subject to the penalties contained under §1842(j)(2) of the Act. Penalties are assigned after post-pay review depending on the severity.

D. Questionable Business Arrangements

No special charge or payment constraints are imposed on tests performed by a physician or a technician under the physician's supervision. There are two requirements for all diagnostic tests under §1861(s)(3) of the Act, as implemented by 42 CFR §410.32 and section 10 of chapter 13 of this publication and section 80, chapter 15 of Pub. 100-02BP. Namely, the test must be ordered by the treating practitioner, and the test must be supervised by a physician. However, attempts may be made by the medical diagnostic community to adjust or establish arrangements which continue to allow physicians to profit from other's work or by creating the appearance that the physician has performed or supervised his/her technicians who are employed, contracted, or leased. Some of these arrangements may involve cardiac scanning services and mobile ultrasound companies leasing their equipment to physicians for the day the equipment is used, and hiring out their staff to the physicians to meet the supervision requirement.

The bona fides of such arrangements may be suspect and could be an attempt to circumvent the *anti-markup payment limitation*. If you have any doubt that a particular arrangement is a valid

relationship where the physician is performing or supervising the services, this should be investigated. The Office of the Inspector General (OIG) has responsibility for investigating violations of §1842(n) of the Act.

Another arrangement to circumvent the *anti-markup payment limitation* is for the ordering physician to reassign his/her payment for the interpretation of the test to the supplier. The supplier, in turn, bills for both the test and the interpretation and pays the ordering physician a fee for the interpretation. This arrangement violates §1842(b)(6) of the Act, which prohibits Medicare from paying benefits due the person that furnished the service to any other person, subject to limited exceptions discussed in *Pub. 100-04, chapter 1, §30.2.2*. Also, this arrangement could constitute a violation of §1128 B (b) of the Act, which prohibits remuneration for referrals (i.e., kickbacks).

Violations of §1128B (b) of the Act may subject the physician or supplier to criminal penalties or exclusion from the Medicare and Medicaid programs. Illegal remuneration for referrals can be found even when the ordering physician performs some service for the remuneration.

20.3 - Payment

(Rev.1931, Issued: 03-12-10, Effective: 06-14-10, Implementation: 06-14-10)

There is no Part B deductible for screening mammographies, however, coinsurance is applicable. The *anti-markup payment limitation* on physician billing for diagnostic tests does not apply to these services. Following are three categories of billing for mammography services:

- Professional component of mammography services (that is the physician's interpretation of the results of the examination);
- Technical component (all other services); or
- Both professional and technical components (global). However, global billing is not permitted for services furnished in provider outpatient departments, except for CAHs electing the optional method of payment for mammography services furnished on or after January 1, 2002.

20.5 - Billing Requirements – Carrier/B MAC Claims

(Rev.1931, Issued: 03-12-10, Effective: 06-14-10, Implementation: 06-14-10)

Contractors use the weekly-updated file to verify that the billing facility is certified by the FDA to perform mammography services, and has the appropriate certification to perform the type of mammogram billed (film and/or digital). Carriers/B MACs match the FDA assigned, 6-digit mammography certification number on the claim to the FDA mammography certification number appearing on the file for the billing facility. Carriers/B MACs complete the following activities in processing mammography claims:

- If the claim does not contain the facility's 6-digit certification number, or if a 6-digit certification number is not reported in item 32 of the Form CMS-1500 for paper claims, or in the 2400 loop (REF 02 segment, where 01=EW segment) of the ASC X12N 837 professional claim format, version 4010A1, for electronic claims, then carriers/B MACs return the claim as unprocessable.
- If the claim contains a 6-digit certification number that is reported in the proper field or segment (as specified in the previous bullet) but such number does not correspond to the number specified in the MQSA file for the facility, then carriers/B MACs deny the claim.
- When a film mammography HCPCS code is on a claim, the claim is checked for a "1" film indicator.
- If a film mammography HCPCS code comes in on a claim and the facility is certified for film mammography, the claim is paid if all other relevant Medicare criteria are met.
- If a film mammography HCPCS code is on a claim and the facility is certified for digital mammography only, the claim is denied.
- When a digital mammography HCPCS code is on a claim, the claim is checked for "2" digital indicator.

- If a digital mammography HCPCS code is on a claim and the facility is certified for digital mammography, the claim is paid if all other relevant Medicare criteria are met.
- If a digital mammography HCPCS code is on a claim and the facility is certified for film mammography only, the claim is denied.
- Process the claim to the point of payment based on the information provided on the claim and in carrier claims history.
- Identify the claim as a screening mammography claim by the CPT-4 code listed in field 24D and the diagnosis code(s) listed in field 21 of Form CMS-1500.
- Assign physician specialty code 45 to facilities that are certified to perform only screening mammography.
- Ensure that entities that bill globally for screening mammography contain a blank in modifier modifier position #1.
- Ensure that entities that bill for the technical component use only HCPCS modifier “-TC.”
- Ensure that physicians who bill the professional component separately use HCPCS modifier “-26.”
- Send the mammography modifier to CWF in the first modifier position on the claim. If more than one modifier is necessary, e.g., if the service was performed in a rural Health Manpower Shortage Area (HMSA) facility, instruct providers to bill the mammography modifier in modifier position 1 and the rural (or other) modifier in modifier position 2.
- Ensure all those who are qualified include the 6-digit FDA-assigned certification number of the screening center in field 32 of Form CMS-1500 and in the REF02 segment (where 01 = EW segment) of the 2400 loop for the ASC X12N 837 professional claim format, version 4010A1. Carriers/B MACs retain this number in their provider files.
- Waive Part B deductible and apply coinsurance for a screening mammography.
- Add diagnosis code V76.12 if a claim comes in for screening mammography without a diagnosis and the carrier file data shows this is appropriate. If there are other diagnoses on the claim, but not code V76.12, add it. (Do not change or overlay code V76.12 but ADD it.) At a minimum, edit for age, frequency, and place of service (POS).
- After May 23, 2008, accept the screening mammography facility’s NPI number in place of the attending/referring physician NPI number for self-referred mammography claims.
- When a mammography claim *contains services subject to the anti-markup payment limitation* and the service *was acquired* from another billing jurisdiction, the provider must submit their own NPI with the name, address, and zip code of the performing physician/supplier.

- Refer to Pub. 100-04, chapter 1, section 10.1.1.1., for claims processing instructions for payment jurisdiction on Form CMS-1500 and electronic form ANSI X12 837P.

NOTE: Beginning October 1, 2003, carriers/B MACs are no longer permitted to add the ICD-9 code for a screening mammography when the screening mammography claim has no diagnosis code. Screening mammography claims with no diagnosis code must be returned as unprocessable for assigned claims. For unassigned claims, deny the claim.

Carrier Provider Education

- Educate providers that when a screening mammography turns to a diagnostic mammography on the same day for the same beneficiary, add the “-GG” modifier to the diagnostic code and bill both codes on the same claim. Both services are reimbursable by Medicare.
- Educate providers that they cannot bill an add-on code without also billing for the appropriate mammography code. If just the add-on code is billed, the service will be denied. Both the add-on code and the appropriate mammography code should be on the same claim.
- Educate providers to submit their own NPI in place of an attending/referring physician NPI in cases where screening mammography services are self-referred.

10.4 - Items 14-33 - Provider of Service or Supplier Information *(Rev.1931, Issued: 03-12-10, Effective: 06-14-10, Implementation: 06-14-10)*

Reminder: For date fields other than date of birth, all fields shall be one or the other format, 6-digit: (MM | DD | YY) or 8-digit: (MM | DD | CCYY). Intermixing the two formats on the claim is not allowed.

Item 14 - Enter either an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of current illness, injury, or pregnancy. For chiropractic services, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of the initiation of the course of treatment and enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date in item 19.

Item 15 - Leave blank. Not required by Medicare.

Item 16 - If the patient is employed and is unable to work in his/her current occupation, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date when patient is unable to work. An entry in this field may indicate employment related insurance coverage.

Item 17 - Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician. All physicians who order services or refer Medicare beneficiaries must report this data. When a claim involves multiple referring and/or ordering physicians, a separate Form CMS-1500 shall be used for each ordering/referring physician.

The term "physician" when used within the meaning of §1861(r) of the Act and used in connection with performing any function or action refers to:

1. A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he/she performs such function or action;
2. A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State in which he/she performs such functions and who is acting within the scope of his/her license when performing such functions;
3. A doctor of podiatric medicine for purposes of §§(k), (m), (p)(1), and (s) and §§1814(a), 1832(a)(2)(F)(ii), and 1835 of the Act, but only with respect to functions which he/she is legally authorized to perform as such by the State in which he/she performs them;
4. A doctor of optometry, but only with respect to the provision of items or services described in §1861(s) of the Act which he/she is legally authorized to perform as a doctor of optometry by the State in which he/she performs them; or
5. A chiropractor who is licensed as such by a State (or in a State which does not license chiropractors as such), and is legally authorized to perform the services of a chiropractor in the jurisdiction in which he/she performs such services, and who meets uniform minimum standards specified by the Secretary, but only for purposes of §§1861(s)(1) and 1861(s)(2)(A) of the Act, and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation). For the purposes of §1862(a)(4) of the Act and subject to the limitations and conditions provided above, chiropractor includes a doctor of one of the arts specified in the

statute and legally authorized to practice such art in the country in which the inpatient hospital services (referred to in §1862(a)(4) of the Act) are furnished.

Referring physician - is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.

Ordering physician - is a physician or, when appropriate, a non-physician practitioner who orders non-physician services for the patient. See Pub 100-02, Medicare Benefit Policy Manual, chapter 15 for non-physician practitioner rules. Examples of services that might be ordered include diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, durable medical equipment, and services incident to that physician's or non-physician practitioner's service.

The ordering/referring requirement became effective January 1, 1992, and is required by §1833(q) of the Act. **All claims** for Medicare covered services and items that are the result of a physician's order or referral shall include the ordering/referring physician's name. See Items 17a and 17b below for further guidance on reporting the referring/ordering provider's UPIN and/or NPI. The following services/situations require the submission of the referring/ordering provider information:

- Medicare covered services and items that are the result of a physician's order or referral;
- Parenteral and enteral nutrition;
- Immunosuppressive drug claims;
- Hepatitis B claims;
- Diagnostic laboratory services;
- Diagnostic radiology services;
- Portable x-ray services;
- Consultative services;
- Durable medical equipment;
- When the ordering physician is also the performing physician (as often is the case with in-office clinical laboratory tests);
- When a service is incident to the service of a physician or non-physician practitioner, the name of the physician or non-physician practitioner who performs the initial service and orders the non-physician service must appear in item 17;

- When a physician extender or other limited licensed practitioner refers a patient for consultative service, submit the name of the physician who is supervising the limited licensed practitioner;

Item 17a – Enter the ID qualifier 1G, followed by the CMS assigned UPIN of the referring/ordering physician listed in item 17. All physicians who order services or refer Medicare beneficiaries must report this data.

NOTE: Effective May 23, 2008, 17a is not to be reported but 17b **MUST** be reported when a service was ordered or referred by a physician.

Item 17b Form CMS-1500 – Enter the NPI of the referring/ordering physician listed in item 17. All physicians who order services or refer Medicare beneficiaries must report this data.

NOTE: Effective May 23, 2008, 17a is not to be reported but 17b **MUST** be reported when a service was ordered or referred by a physician.

Item 18 - Enter either an 8-digit (MM | DD | CCYY) or a 6-digit (MM | DD | YY) date when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

Item 19 - Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) date patient was last seen and the UPIN (NPI when it becomes effective) of his/her attending physician when a physician providing routine foot care submits claims.

For physical therapy, occupational therapy or speech-language pathology services, effective for claims with dates of service on or after June 6, 2005, the date last seen and the UPIN/NPI of an ordering/referring/attending/certifying physician or non-physician practitioner are not required. If this information is submitted voluntarily, it must be correct or it will cause rejection or denial of the claim. However, when the therapy service is provided incident to the services of a physician or nonphysician practitioner, then incident to policies continue to apply. For example, for identification of the ordering physician who provided the initial service, see Item 17 and 17a, and for the identification of the supervisor, see item 24J of this section.

NOTE: Effective May 23, 2008, all identifiers submitted on the Form CMS-1500 **MUST** be in the form of an NPI.

Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) x-ray date for chiropractor services (if an x-ray, rather than a physical examination was the method used to demonstrate the subluxation). By entering an x-ray date and the initiation date for course of chiropractic treatment in item 14, the chiropractor is certifying that all the relevant information requirements (including level of subluxation) of Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, is on file, along with the appropriate x-ray and all are available for carrier review.

Enter the drug's name and dosage when submitting a claim for Not Otherwise Classified (NOC) drugs.

Enter a concise description of an "unlisted procedure code" or an NOC code if one can be given within the confines of this box. Otherwise an attachment shall be submitted with the claim.

Enter all applicable modifiers when modifier -99 (multiple modifiers) is entered in item 24d. If modifier -99 is entered on multiple line items of a single claim form, all applicable modifiers for each line item containing a -99 modifier should be listed as follows: 1=(mod), where the number 1 represents the line item and "mod" represents all modifiers applicable to the referenced line item.

Enter the statement "Homebound" when an independent laboratory renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient. (See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," and Pub. 100-04, Medicare Claims Processing Manual, Chapter 16, "Laboratory Services From Independent Labs, Physicians and Providers," and Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, "Definitions," respectively for the definition of "homebound" and a more complete definition of a medically necessary laboratory service to a homebound or an institutional patient.)

Enter the statement, "Patient refuses to assign benefits" when the beneficiary absolutely refuses to assign benefits to a non-participating physician/supplier who accepts assignment on a claim. In this case, payment can only be made directly to the beneficiary.

Enter the statement, "Testing for hearing aid" when billing services involving the testing of a hearing aid(s) is used to obtain intentional denials when other payers are involved.

When dental examinations are billed, enter the specific surgery for which the exam is being performed.

Enter the specific name and dosage amount when low osmolar contrast material is billed, but only if HCPCS codes do not cover them.

Enter a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) assumed and/or relinquished date for a global surgery claim when providers share post-operative care.

Enter demonstration ID number "30" for all national emphysema treatment trial claims.

Enter the NPI/PIN of the physician who is performing *the technical or professional component* of a diagnostic test *that is subject to the anti-markup payment limitation*. (See Pub. 100-04, chapter 1, section 30.2.9 for additional information.)

NOTE: Effective May 23, 2008, all identifiers submitted on the Form CMS-1500 MUST be in the form of an NPI.

Method II suppliers shall enter the most current HCT value for the injection of Aranesp for ESRD beneficiaries on dialysis. (See Pub. 100-04, chapter 8, section 60.7.2.)

Individuals and entities who bill carriers or A/B MACs for administrations of ESAs or Part B anti-anemia drugs not self-administered (other than ESAs) in the treatment of cancer must enter the most current hemoglobin or hematocrit test results. The test results shall be entered as follows: TR= test results (backslash), R1=hemoglobin, or R2=hematocrit (backslash), and the

most current numeric test result figure up to 3 numerics and a decimal point [xx.x]). Example for hemoglobin tests: TR/R1/9.0, Example for Hematocrit tests: TR/R2/27.0.

Item 20 - Complete this item when billing for diagnostic tests subject to *the anti-markup payment* limitation. Enter the *acquisition* price under charges if the "yes" block is checked. A "yes" check indicates that an entity other than the entity billing for the service performed the diagnostic test. A "no" check indicates "no *anti-markup* tests are included on the claim." When "yes" is annotated, item 32 shall be completed. When billing for multiple *anti-markup* tests, each test shall be submitted on a separate claim Form CMS-1500. Multiple *anti-markup* tests may be submitted on the ASC X12 837 electronic format as long as appropriate line level information is submitted when services are rendered at different service facility locations. See chapter 1.

NOTE: This is a required field when billing for diagnostic tests subject to *the anti-markup payment* limitation.

Item 21 - Enter the patient's diagnosis/condition. With the exception of claims submitted by ambulance suppliers (specialty type 59), all physician and nonphysician specialties (i.e., PA, NP, CNS, CRNA) use an ICD-9-CM code number and code to the highest level of specificity for the date of service. Enter up to four diagnoses in priority order. All narrative diagnoses for nonphysician specialties shall be submitted on an attachment.

Item 22 - Leave blank. Not required by Medicare.

Item 23 - Enter the Quality Improvement Organization (QIO) prior authorization number for those procedures requiring QIO prior approval.

Enter the Investigational Device Exemption (IDE) number when an investigational device is used in an FDA-approved clinical trial. Post Market Approval number should also be placed here when applicable.

For physicians performing care plan oversight services, enter the 6-digit Medicare provider number (or NPI) of the home health agency (HHA) or hospice when CPT code G0181 (HH) or G0182 (Hospice) is billed.

Enter the 10-digit Clinical Laboratory Improvement Act (CLIA) certification number for laboratory services billed by an entity performing CLIA covered procedures.

NOTE: Item 23 can contain only one condition. Any additional conditions should be reported on a separate Form CMS-1500.

Item 24 - The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and legacy identifier during the NPI transition and to accommodate the submission of supplemental information to support the billed service. The top portion in each of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 service lines.

When required to submit NDC drug and quantity information for Medicaid rebates, submit the NDC code in the red shaded portion of the detail line item in positions 01 through position 13. The NDC is to be preceded with the qualifier N4 and followed immediately by the 11 digit NDC code (e.g. N499999999999). Report the NDC quantity in positions 17 through 24 of the same red shaded portion. The quantity is to be preceded by the appropriate qualifier: UN (units), F2 (international units), GR (gram) or ML (milliliter). There are six bytes available for quantity. If the quantity is less than six bytes, left justify and space-fill the remaining positions (e.g. UN2 or F2999999).

Item 24A - Enter a 6-digit or 8-digit (MMDDCCYY) date for each procedure, service, or supply. When "from" and "to" dates are shown for a series of identical services, enter the number of days or units in column G. This is a required field. Return as unprocessable if a date of service extends more than 1 day and a valid "to" date is not present.

Item 24B - Enter the appropriate place of service code(s) from the list provided in section 10.5. Identify the location, using a place of service code, for each item used or service performed. This is a required field.

NOTE: When a service is rendered to a hospital inpatient, use the "inpatient hospital" code.

Item 24C - Medicare providers are not required to complete this item.

Item 24D - Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code. When applicable, show HCPCS code modifiers with the HCPCS code. The Form CMS-1500 has the ability to capture up to four modifiers.

Enter the specific procedure code without a narrative description. However, when reporting an "unlisted procedure code" or a "not otherwise classified" (NOC) code, include a narrative description in item 19 if a coherent description can be given within the confines of that box. Otherwise, an attachment shall be submitted with the claim. This is a required field.

Return as unprocessable if an "unlisted procedure code" or an (NOC) code is indicated in item 24d, but an accompanying narrative is not present in item 19 or on an attachment.

Item 24E - Enter the diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line item. When multiple services are performed, enter the primary reference number for each service, either a 1, or a 2, or a 3, or a 4. This is a required field.

If a situation arises where two or more diagnoses are required for a procedure code (e.g., pap smears), the provider shall reference only one of the diagnoses in item 21.

Item 24F- Enter the charge for each listed service.

Item 24G - Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered.

Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., multiple ostomy or urinary supplies, medication dosages, or allergy testing procedures). When multiple services are provided, enter the actual number provided.

For anesthesia, show the elapsed time (minutes) in item 24g. Convert hours into minutes and enter the total minutes required for this procedure.

For instructions on submitting units for oxygen claims, see chapter 20, section 130.6 of this manual.

NOTE: This field should contain at least 1 day or unit. The carrier should program their system to automatically default "1" unit when the information in this field is missing to avoid returning as unprocessable.

Item 24H - Leave blank. Not required by Medicare.

Item 24I - Enter the ID qualifier 1C in the shaded portion.

Item 24J - Enter the rendering provider's PIN in the shaded portion. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the PIN of the supervisor in the shaded portion.

Enter the rendering provider's NPI number in the lower unshaded portion. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the NPI of the supervisor in the lower unshaded portion.

This unprocessable instruction does not apply to influenza virus and pneumococcal vaccine claims submitted on roster bills as they do not require a rendering provider NPI.

NOTE: Effective May 23, 2008, the shaded portion of 24J is not to be reported.

Item 25 - Enter the provider of service or supplier Federal Tax ID (Employer Identification Number or Social Security Number) and check the appropriate check box. Medicare providers are not required to complete this item for crossover purposes since the Medicare contractor will retrieve the tax identification information from their internal provider file for inclusion on the COB outbound claim. However, tax identification information is used in the determination of accurate National Provider Identifier reimbursement. Reimbursement of claims submitted without tax identification information will/may be delayed.

Item 26 - Enter the patient's account number assigned by the provider's of service or supplier's accounting system. This field is optional to assist the provider in patient identification. As a service, any account numbers entered here will be returned to the provider.

Item 27 - Check the appropriate block to indicate whether the provider of service or supplier accepts assignment of Medicare benefits. If Medigap is indicated in item 9 and Medigap payment authorization is given in item 13, the provider of service or supplier shall also be a

Medicare participating provider of service or supplier and accept assignment of Medicare benefits for all covered charges for all patients.

The following providers of service/suppliers and claims can only be paid on an assignment basis:

- Clinical diagnostic laboratory services;
- Physician services to individuals dually entitled to Medicare and Medicaid;
- Participating physician/supplier services;
- Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, and clinical social workers;
- Ambulatory surgical center services for covered ASC procedures;
- Home dialysis supplies and equipment paid under Method II;
- Ambulance services;
- Drugs and biologicals; and
- Simplified Billing Roster for influenza virus vaccine and pneumococcal vaccine.

Item 28 - Enter total charges for the services (i.e., total of all charges in item 24f).

Item 29 - Enter the total amount the patient paid on the covered services only.

Item 30 - Leave blank. Not required by Medicare.

Item 31 - Enter the signature of provider of service or supplier, or his/her representative, and either the 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or alpha-numeric date (e.g., January 1, 1998) the form was signed.

In the case of a service that is provided incident to the service of a physician or non-physician practitioner, when the ordering physician or non-physician practitioner is directly supervising the service as in 42 CFR 410.32, the signature of the ordering physician or non-physician practitioner shall be entered in item 31. When the ordering physician or non-physician practitioner is not supervising the service, then enter the signature of the physician or non-physician practitioner providing the direct supervision in item 31.

NOTE: This is a required field, however the claim can be processed if the following is true. If a physician, supplier, or authorized person's signature is missing, but the signature is on file; or if any authorization is attached to the claim or if the signature field has "Signature on File" and/or a computer generated signature.

Item 32 - Enter the name and address, and ZIP Code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office. Effective for claims received on or after April 1, 2004, enter the name, address, and ZIP Code of the service location for all services other than those furnished in place of service home – 12. Effective for claims received on or after April 1, 2004, on the Form CMS-1500, only one name, address and ZIP Code may be entered in the block. If additional entries are needed, separate claim forms shall be submitted.

Providers of service (namely physicians) shall identify the supplier's name, address, and ZIP Code when billing for *anti-markup* tests. When more than one supplier is used, a separate Form CMS-1500 shall be used to bill for each supplier. *(See Pub. 100-04, chapter 1, §10.1.1.2 for more information on payment jurisdiction for claims subject to the anti-markup limitation.)*

For foreign claims, only the enrollee can file for Part B benefits rendered outside of the United States. These claims will not include a valid ZIP Code. When a claim is received for these services on a beneficiary submitted Form CMS-1490S, before the claim is entered in the system, it should be determined if it is a foreign claim. If it is a foreign claim, follow instructions in chapter 1 for disposition of the claim. The carrier processing the foreign claim will have to make necessary accommodations to verify that the claim is not returned as unprocessable due to the lack of a ZIP Code.

For durable medical, orthotic, and prosthetic claims, the name and address of the location where the order was accepted must be entered (*DME MAC* only). This field is required. When more than one supplier is used, a separate Form CMS-1500 shall be used to bill for each supplier. This item is completed whether the supplier's personnel performs the work at the physician's office or at another location.

If a modifier is billed, indicating the service was rendered in a Health Professional Shortage Area (HPSA) or Physician Scarcity Area (PSA), the physical location where the service was rendered shall be entered if other than home.

If the supplier is a certified mammography screening center, enter the 6-digit FDA approved certification number.

Complete this item for all laboratory work performed outside a physician's office. If an independent laboratory is billing, enter the place where the test was performed.

Item 32a - If required by Medicare claims processing policy, enter the NPI of the service facility.

Item 32b - If required by Medicare claims processing policy, enter the PIN of the service facility. Be sure to precede the PIN with the ID qualifier of 1C. There should be one blank space between the qualifier and the PIN.

NOTE: Effective May 23, 2008, Item 32b is not to be reported.

Item 33 - Enter the provider of service/supplier's billing name, address, ZIP Code, and telephone number. This is a required field.

Item 33a - Enter the NPI of the billing provider or group. This is a required field.

Item 33b - Enter the ID qualifier 1C followed by one blank space and then the PIN of the billing provider or group. Suppliers billing the DME MAC will use the National Supplier Clearinghouse (NSC) number in this item.

NOTE: Effective May 23, 2008, Item 33b is not to be reported.

Medicare Claims Processing Manual

Chapter 35 – Independent Diagnostic Testing Facility (IDTF)

Table of Contents *(Rev. 1931, 03-12-10)*

30 - *Diagnostic Tests Subject to the Anti-Markup Payment Limitation*

10.2 - Claims Processing

(Rev.1931, Issued: 03-12-10, Effective: 06-14-10, Implementation: 06-14-10)

A. Billing Issues

Nothing in this document or in the Medicare Enrollment Application, (CMS-855B) or the Internet-based Provider Enrollment, Chain and Ownership System shall be construed or interpreted to authorize billing by an IDTF, physician, physician group practice, or any other entity that would otherwise violate the physician self-referral prohibition set forth in §1877 of the Social Security Act and related regulations. Carriers must deny claims submitted in violation of §1877 and demand refunds of any payments that have been made in violation of §1877.

Consistent with 42 CFR 410.32(a), the supervisory physician for the IDTF, whether or not for a mobile unit, may not order tests to be performed by the IDTF, unless the supervisory physician is the patient's treating physician and is not otherwise prohibited from referring to the IDTF. The supervisory physician is the patient's treating physician if he or she furnishes a consultation or treats the patient for a specific medical problem and uses the test results in the management of the patient's medical problem.

If an IDTF wants to bill for an interpretation performed by *a physician who does not share a practice with the IDTF*, the IDTF must meet *certain* conditions concerning *the anti-markup payment limitation*. *If a physician working for an IDTF (or a party related to the IDTF through common ownership or control as described in 42 CFR §413.17) does not order the TC or PC of a diagnostic test (excluding clinical diagnostic laboratory tests), it would not be subject to the anti-markup payment limitation. (See Pub. 100-04, chapter 1, §30.2.9)*

B. Transtelephonic and Electronic Monitoring Services

Transtelephonic and electronic monitoring services (e.g. twenty four hour ambulatory EKG monitoring, pacemaker monitoring and cardiac event detection) may perform some of their services without actually seeing the patient. Most but not all of these billing codes are, 93012, 93014, 93040, 93224, 93225, 93226, 93232, 93230, 93231, 93233, 93236, 93270, 93271, 93731, 93733, 93736, 95953, 95956, These monitoring service entities should be classified as IDTFs and must meet all IDTF requirements. We currently do not have specific certification standards for their technicians; technician credentialing requirements for them are at carrier discretion. They do require a supervisory physician who performs General Supervision. Final enrollment of a transtelephonic or electronic monitoring service as an IDTF requires a site visit.

For any entity that lists and will bill codes 93012, 93014, 93268, 93270, 93271, 93272, the carrier must make a written determination that the entity actually has a person available on a 24 hour basis to answer telephone inquiries. Use of an answering service in lieu of the actual person is not acceptable. The person performing the attended monitoring should be listed in Section 3 of Attachment 2 of Form CMS-855B. The qualifications of the person are at the carrier's discretion. The carrier shall check that the person is available by attempting to contact the applicant during non-standard business hours. In Particular, at least one of the contact calls should be made between midnight and 6:00 AM. If the applicant does not meet the availability standard they should receive a denial.

C. Slide Preparation Facilities and Radiation Therapy Centers

Slide Preparation Facilities and Radiation Therapy Centers are not IDTFs. Slide preparation facilities are entities that provide slide preparation services and other kinds of services that are payable through the technical component of the surgical pathology service. These entities do not provide the professional component of surgical pathology services or other kinds of laboratory tests. The services that they provide are recognized by carriers for payment, as codes in the surgical pathology code range (88300) to (88399) with a technical component value under the physician fee schedule. The services provided by these entities are usually ordered by and reviewed by a dermatologist. Slide preparation facilities generally only have one or two people performing this service.

All enrolled Slide Preparation Facilities must enroll separately with their Medicare contractor. Radiation therapy centers provide therapeutic services and therefore are not IDTFs. Radiation therapy centers must enroll separately with their Medicare contractor.

30 – *Diagnostic Tests Subject to the Anti-Markup Payment Limitation* ***(Rev.1931, Issued: 03-12-10, Effective: 06-14-10, Implementation: 06-14-10)***

In most instances, physicians working for an IDTF do not order diagnostic tests because such tests are generally ordered by the patient's treating physician. If a physician working for an IDTF does not order a diagnostic test, the test is not subject to the anti-markup payment limitation. However, if a physician working for an IDTF (or a physician financially related to the IDTF through common ownership or control) orders a diagnostic test payable under the Medicare Physician Fee Schedule (MPFS), the anti-markup payment limitation may apply (depending on whether the performing physician or other supplier meets the "sharing a practice" requirements). For additional information, see Pub. 100-04, chapter 1, §30.2.9.

If a physician working for an IDTF (or a physician financially related to the IDTF through common ownership or control) orders and the IDTF bills for a diagnostic test that is performed by another physician or supplier, the performing physician or other supplier must be enrolled in the Medicare program. No formal reassignment is necessary; however, reassigned diagnostic testing services may also be subject to the anti-markup payment limitation.

The billing entity must report on the CMS 1500 claim form (or corresponding loop and segment of the ANSI X12N 837) the name, NPI, and address of the performing physician or other supplier. The acquisition price of the either the TC or PC of the diagnostic test must also be reported on the claim.

Effective for claims with dates of service on or after January 25, 2005, carriers must accept and process claims for *diagnostic tests subject to the anti-markup payment limitation* 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. *For services furnished outside the B/MAC jurisdiction in which the billing entity is enrolled, the billing entity must submit its own NPI with the name, address, and ZIP code of the performing physician or other supplier in the appropriate data field. (The billing physician or other supplier should maintain a record of the performing physician or other supplier's NPI in the clinical record for auditing purposes.)* Effective April 1, 2005, carriers must price claims for

diagnostic tests that are subject to the anti-markup payment limitation based on the ZIP Code of the location where the service was rendered, using a CMS-supplied abstract file containing the HCPCS codes that are payable under the MPFS as *an anti-markup test* for the calendar year. (See Pub. 100-04, chapter 23, §30.6 and Addendum for record layouts and instructions for downloading the Abstract File for Purchased Diagnostic Tests/Interpretations.) Carriers must pay the *lesser of: (a) the net acquisition price, (b) the billing entity's actual charge, or (c) the fee schedule amount as if the test was billed by the performing supplier.*

NOTE: As with all services payable under the MPFS, the ZIP Code is used to determine the appropriate payment locality and corresponding fee *that is used to price the service that is subject to the anti-markup payment limitation.* When a ZIP Code crosses county lines, CMS uses the dominant locality to determine the corresponding fee.