CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1250	**Date: MAY 25, 2007**
	Change Request 5543

SUBJECT: Implementation of the Carrier Jurisictional Pricing Rules for All Purchased Diagnostic Service Claims

I. SUMMARY OF CHANGES: This Change Request (CR) replaces the temporary physician billing instructions specified in CR 3630 (Transmittal 415, issued on December 23, 2004) with new billing procedures to allow all physicians/suppliers to receive the correct payment amount for purchased diagnostic services, based on the ZIP code of the location where the service was rendered, in accordance with the carrier jurisdictional pricing rules specified in Chapter 1, (Section) 10.1.1 of the Medicare Claims Processing Manual.

New / Revised Material
Effective Date: October 1, 2007
Implementation Date: October 1, 2007

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-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	1/30.2.9/Payment to Physician or Other Supplier for Purchased Diagnostic Tests - Claims Submitted to Carriers
R	1/30.2.9.1/Payment to Supplier of Diagnostic Tests for Purchased Interpretations

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1250	Date: May 25, 2007	Change Request: 5543

SUBJECT: Implementation of the Carrier Jurisdictional Pricing Rules for All Purchased Diagnostic Service Claims

Effective Date: October 1, 2007

Implementation Date: October 1, 2007

I. GENERAL INFORMATION

A. Background: In accordance with Change Request 3481 (Transmittal 341, issued on October 29, 2004), the Centers for Medicare and Medicaid Services (CMS) implemented a national abstract file of the Medicare Physician Fee Schedule (MPFS) containing the Healthcare Common Procedural Coding System (HCPCS) codes billable as a purchased diagnostic test/interpretation, for every locality throughout the country. Effective with the implementation of the national abstract file on April 1, 2005, CMS changed the carrier jurisdictional pricing rules for purchased diagnostic services to allow suppliers (including laboratories, physicians, and independent diagnostic testing facilities) to bill their local carriers for these services, regardless of the location where the service was performed. (Carrier jurisdictional pricing rules for all other services payable under the MPFS have remained in effect.)

Prior to the implementation of the national abstract file, CMS became aware of a potential problem with reporting the locality data related to physician claims for purchased diagnostic tests/interpretations when these services are performed outside of the local carrier's jurisdiction. Therefore, CMS delayed the implementation of the billing instructions specified in CR 3481 when the claim is billed by a physician for purchased tests/interpretations performed outside of the carrier's geographical service area. In lieu of these instructions, CMS implemented a temporary change in the carrier jurisdictional pricing rules for purchased diagnostic services to allow physicians purchasing out-of-jurisdiction diagnostic tests/interpretations to bill their local carrier for these services and receive the local rate. (See CR 3630, Transmittal 415, issued on December 23, 2004 and CR 3694, Transmittal 464, issued on February 4, 2005.)

This CR replaces the temporary physician billing instructions specified in CR 3630 with new billing procedures to allow physicians/suppliers to receive the correct payment amount for all purchased diagnostic services, including those performed outside of their local carrier's/Medicare Administrative Contractor's (MAC) jurisdiction, based on the ZIP code of the location where the service was rendered, in accordance with the carrier jurisdictional pricing rules.

B. Policy: Effective for claims with dates of service on or after October 1, 2007, carriers/MACs shall use the national abstract file for purchased diagnostic tests/interpretations to price all claims for purchased diagnostic services based on the ZIP code of the location where the service was rendered, in accordance with the carrier jurisdictional pricing rules specified in Chapter 1, §10.1.1 of the Medicare Claims Processing Manual. Carriers/MACs shall implement the revised billing procedures for physician claims included in this CR in accordance with the business requirements specified in CR 3481 (Transmittal 341, issued on October 29, 2004) and CR 3694 (Transmittal 464, issued on February 4, 2005) for the implementation of the MPFS national abstract file.

Carriers/MACs shall instruct physicians/suppliers to begin reporting the rendering physician's/supplier's information and the location where the service was rendered on all claims for purchased tests/interpretations with dates of services on or after October 1, 2007, including those for tests/interpretations performed outside of

the local carrier's jurisdiction, following the instructions in Chapter 1, §10.1.1.2 and §30.2.9 of the Medicare Claims Processing Manual for submitting purchased diagnostic service claims. In accordance with these instructions, carriers/MACs shall also instruct physicians/suppliers not to report the National Provider Identifier (NPI)/Provider Identification Number (PIN) of the out-of-jurisdiction performing physician/supplier when submitting a claim for a diagnostic service purchased outside of their local carrier's/MACs jurisdiction. (Physicians/suppliers must maintain this information on file and provide it, upon request, to their local carrier/MAC.)

Carriers/MACs shall conduct provider education activities to remind physicians/suppliers that they may only submit claims for purchased tests/interpretations when these services are performed within the United States. (In this context, the term "United States" means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa. See Chapter 1, §10.1.4 of the Medicare Claims Processing Manual for additional information.)

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5543.1	Effective for claims with dates of service on or after October 1, 2007, carriers/MACS shall use the national abstract file for purchased diagnostic tests/interpretations to price all claims for purchased diagnostic services based on the ZIP code of the location where the service was rendered, including those submitted by physicians for purchased diagnostic services performed outside of the local carrier's jurisdiction, in accordance with the carrier jurisdictional pricing rules specified in Chapter 1, §10.1.1 of the Medicare Claims Processing Manual.	X			X							
5543.2	Carriers/MACs shall instruct physicians/suppliers to begin reporting the rendering physician's/supplier's information and the location where the service was rendered on all claims for purchased tests/interpretations with dates of services on or after October 1, 2007, including those for tests/interpretations performed outside of the local carrier's jurisdiction, following the instructions in Chapter 1, §10.1.1.2 and §30.2.9 of the Medicare Claims Processing Manual for submitting a purchased diagnostic service claim.	X			X							
5543.2.1	Carriers/MACs shall instruct physicians/suppliers not	X			X							

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	to report the NPI/PIN of the out-of-jurisdiction physician/supplier when submitting a claim for a diagnostic service purchased outside of the local carrier's/MAC's jurisdiction, in accordance with the instructions for submitting a purchased diagnostic service claim.											

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5543.3	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. 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 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.	X			X							
5543.4	Carriers/MACs shall conduct provider education activities to remind physicians/suppliers that they may only submit claims for purchased tests/interpretations when these services are provided within the United States (the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the	X			X							

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	Virgin Islands, Guam, the Northern Mariana Islands and American Samoa).											

IV. SUPPORTING INFORMATION

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:
5543.1-5543.2.1	Implement in accordance with the business requirements specified in CR 3481, Transmittal 341, issued on October 29, 2004 and CR 3694, Transmittal 464, issued on February 4, 2005.

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

V. CONTACTS

Pre-Implementation Contact(s): Wendy Knarr, Contact Wendy by email Wendy.Knarr@cms.hhs.gov or by dialing National Relay at #711 and have relay agent dial (410) 786-0843.

Post-Implementation Contact(s): Contact the appropriate regional office.

VI. FUNDING

A. *For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC),* use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. *For Medicare Administrative Contractors (MAC),* use the following statement:

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts alloted 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.

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

(Rev. 1250, Issued: 05-25-07, Effective: 10-01-07, Implementation: 10-01-07)

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

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

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

- In order to have appropriate service facility location ZIP code and the purchase price of each test on the claim, when billing for purchased tests on the Form CMS-1500 paper claim form each test must be submitted on a separate claim form. Treat paper claims submitted with more than one purchased test as unprocessable per §80.3.2.
- More than one purchased test may be billed on the ANSI X12N 837 electronic format. When more than one test is billed, the total purchased service amount must be submitted for each service. Treat claims received with multiple purchased tests without line level total purchased service amount information as unprocessable per §80.3.2.
- Treat paper claims submitted for purchased services with both the interpretation and the purchased test on one claim as unprocessable per §80.3.2 unless the services are submitted with the same date of service and same place of service codes. When a claim is received that includes both services, and the date of service and place of service codes match, assume that the one address in Item 32 applies to both services. Effective for claims with dates of service on or after April 1, 2005, each component of the test must be submitted on a separate claim form. Treat paper claims with dates of service after March 31, 2005 submitted with more than one purchased test as unprocessable per §80.3.2.
- ANSI X12N 837 electronic claims submitted for purchased services with both the interpretation and purchased test on the same claim must be accepted. Assume

that the claim level service facility location information applies to both services if line level information is not provided.

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

Effective for claims with dates of service on or after January 25, 2005, carriers must accept and process claims for purchased diagnostic tests when billed by suppliers (including laboratories, physicians, and independent diagnostic testing facilities [IDTFs]) enrolled in the carrier's jurisdiction, regardless of the location where the service was furnished. Effective April 1, 2005, carriers must price purchased diagnostic test claims based on the ZIP code of the location where the service was rendered when billed by a laboratory or an IDTF, using a CMS-supplied *national* abstract file of the Medicare MPFS containing the HCPCS codes that are payable under the MPFS as either a purchased test or interpretation for the calendar year. *Effective for claims with dates of service on or after October 1, 2007, carriers/Medicare Administrative Contractors (MACs) must use the national abstract file to price all claims for purchased diagnostic services, for all provider specialty types (including physicians), based on the ZIP code of the location where the service was rendered, in accordance with the carrier jurisdictional pricing rules specified in §10.1.1.* (See IOM Publication 100-04, chapter 23, §30.6, and Addendum for record layouts and instructions for downloading the Abstract File for Purchased Diagnostic Tests/Interpretations.)

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

30.2.9.1 - Payment to Supplier of Diagnostic Tests for Purchased Interpretations

(Rev. 1250, Issued: 05-25-07, Effective: 10-01-07, Implementation: 10-01-07)

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

- The tests are initiated by a physician or medical group which is independent of the person or entity providing the tests and of the physician or medical group providing the interpretations;
- The physician or medical group providing the interpretations does not see the patient; and
- The purchaser (or employee, partner, or owner of the purchaser) performs the technical component of the test. The interpreting physician must be enrolled in the Medicare program. No formal reassignment is necessary.

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

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

Effective for claims with dates of service on or after January 25, 2005, carriers must accept and process claims for purchased diagnostic interpretations billed by suppliers (including laboratories, physicians, and independent diagnostic testing facilities [IDTFs]) enrolled in the carrier's jurisdiction, for services furnished anywhere in the United States. Effective April 1, 2005, carriers must price claims for purchased interpretations based on the ZIP code of the location where the service was rendered when submitted by a laboratory or IDTF, using a CMS-supplied *national* abstract file of the MPFS containing the HCPCS codes that are payable under the MPFS as either a purchased test or interpretation for the calendar year. *Effective for claims with dates of service on or after October 1, 2007, carriers/MACs must use the national abstract file to price all claims for purchased diagnostic interpretations, for all provider specialty types (including physicians), based on the ZIP code of the location where the service was rendered, in accordance with the carrier jurisdictional pricing rules specified in §10.1.1.* (See IOM Publication 100-04, chapter 23, §30.6, and Addendum for record layouts and instructions for downloading the Abstract File for Purchased Diagnostic Tests/Interpretations.)

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