| CMS Manual System | **Department of Health & Human Services (DHHS)** |
|---|---|
| Pub 100-04 Medicare Claims Processing | **Centers for Medicare & Medicaid Services (CMS)** |
| **Transmittal 2994** | **Date: July 25, 2014** |
| | **Change Request 8769** |

**SUBJECT: Update to Pub. 100-04, Chapter 35 to Provide Language-Only Changes for Updating ASC X12**

**I. SUMMARY OF CHANGES:** This Change Request (CR) contains language-only changes for updating ASC X12 language in Pub 100-04, Chapter 35. Also, references to MACs replace references to the old contractor types in the sections that are included in this CR. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

**EFFECTIVE DATE: January 1, 2012**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: August 25, 2014**

***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 | 35/30/ Diagnostic Tests Subject to the Anti-Markup Payment Limitation |
| R | 35/30.1/ National Provider Identification (NPI) Reported on Claims |

**III. FUNDING:**
**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 obliged 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**

# Attachment - Business Requirements

| Pub. 100-04 | Transmittal: 2994 | Date: July 25, 2014 | Change Request: 8769 |
|---|---|---|---|

**SUBJECT: Update to Pub. 100-04, Chapter 35 to Provide Language-Only Changes for Updating ASC X12**

**EFFECTIVE DATE: January 1, 2012**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: August 25, 2014**

## I. GENERAL INFORMATION

**A. Background:** This Change Request (CR) contains language-only changes for updating ASC X12 language in Pub 100-04, Chapter 35. Also, references to MACs replace references to the old contractor types in the sections that are included in this CR.

**B. Policy:** There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

## II. BUSINESS REQUIREMENTS TABLE

*"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.*

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| 8769.1 | A/B MACs shall be aware of the updated language for ASC X12 in Pub. 100 - 04, Chapter 35. | | X | | | | | | | |

## III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility | | | | |
|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | CEDI |
| | | A | B | HHH | | |
| | None | | | | | |

## IV. SUPPORTING INFORMATION

**Section A: Recommendations and supporting information associated with listed requirements: N/A**

*"Should" denotes a recommendation.*

| X-Ref Requirement Number | Recommendations or other supporting information: |
|---|---|
| | |

**Section B: All other recommendations and supporting information:** N/A

## V. CONTACTS

**Pre-Implementation Contact(s):** Not Applicable

**Post-Implementation Contact(s):** No text defined for ffsReqContactPagePostImplFootNote

## VI. FUNDING

**Section A: 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.

**ATTACHMENTS: 0**

# Medicare Claims Processing Manual
## Chapter 35 – Independent Diagnostic Testing Facility (IDTF)

### 30 - Diagnostic Tests Subject to the Anti-Markup Payment Limitation
***(Rev.2994; Issued: 07-25-14; Effective: 01-01-12; Implementation: 08-25-14 )***

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 *using the ASC X12 837 professional claim format or* on the *Form* CMS-1500 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, *A/B MACs (B)* 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 *A/B MAC's (B)* jurisdiction, for services furnished anywhere in the United States. For services furnished outside the *A/B MAC (B)* 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, *A/B MACs (B)* 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.) *A/B MACs (B)* 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.

### 30.1 - National Provider Identification (NPI) Reported on Claims
***(Rev.2994; Issued: 07-25-14; Effective: 01-01-12; Implementation: 08-25-14)***

Effective for dates of service May 23, 2008 and later, IDTF's must submit the NPI assigned to the ordering physician *using the ASC X12 837 professional claim format or, for paper claims, on* the *Form* CMS-1500.