CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 341 **Date: OCTOBER 29, 2004**

CHANGE REQUEST 3481

SUBJECT: Implementation of the Medicare Physician Fee Schedule (MPFS) National Abstract File for Purchased Diagnostic Tests and Interpretations

I. SUMMARY OF CHANGES: This transmittal implements a national abstract file of the Medicare Physician Fee Schedule (MPFS) containing Healthcare Common Procedural Coding System (HCPCS) codes billable as a purchased diagnostic test/interpretation, for every locality throughout the country. It also changes the carrier jurisdiction rules to allow suppliers to bill their local carrier for these services. Carrier jurisdictional pricing rules for all other services payable under the MPFS remain in effect.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: April 1, 2005
IMPLEMENTATION DATE: April 4, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 not updated*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	1/Table of Contents
R	1/10.1.1/Payment Jurisdiction Among Local Carriers for Services Paid Under the Physician Fee Schedule and Anesthesia Services
R	1/10.1.1.2/Payment Jurisdiction for Purchased Services
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
N	23/30.6/Abstract File for Purchased Diagnostic Tests/Interpretations

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 341	Date: October 29, 2004	Change Request 3481

SUBJECT: Implementation of the Medicare Physician Fee Schedule (MPFS) National Abstract File for Purchased Diagnostic Tests and Interpretations

NOTE: The VIPS shared system and associated Part B Carriers are waived from implementing this change request (CR) due to their upcoming transition to the MCS system. Carriers are required to implement the CR once they transition to MCS.

I. GENERAL INFORMATION

A. Background: In accordance with the Medicare Claims Processing Manual, Publication 100-04, Chapter 1, §10.1.1, effective for claims with dates of service on or after April 1, 2004, Medicare carriers must use the ZIP code of the location where the service was rendered to determine both the carrier jurisdiction for processing the claim and the correct payment locality for any service paid under the Medicare Physician Fee Schedule (MPFS). Diagnostic tests and their interpretations are paid under the MPFS, and are therefore subject to the same payment rules as all other services paid under the MPFS. Laboratories, physicians, and independent diagnostic testing facilities (IDTFs) may bill for purchased tests and interpretations. However, under the current carrier jurisdictional pricing rules, these suppliers must bill the purchased test or interpretation to the carrier that has jurisdiction over the geographic location where the test or service was performed (i.e., the carrier that would be billed by the supplier if the test component or interpretation had not been purchased).

Since the implementation of carrier jurisdictional pricing edits on April 1, 2004, CMS has received reports that, due to current enrollment restrictions, some suppliers purchasing diagnostic tests/interpretations are unable to receive reimbursement for these services when the services are performed outside of their local carrier's jurisdiction. To address this problem, CMS is implementing a national abstract file of the Medicare Physician Fee Schedule (MPFS) containing 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 abstract file in April 2005, carrier jurisdiction rules for purchased diagnostic tests/interpretations will be changed to allow suppliers to bill their local carriers for these services and receive the correct payment amount, regardless of the location where the service was performed. Carrier jurisdictional pricing rules for all other services payable under the MPFS will remain in effect.

B. **Policy:** Effective for claims with dates of service on or after April 1, 2005, carriers must accept and process claims for purchased diagnostic tests/interpretations when billed by suppliers (including laboratories, physicians, and IDTFs) enrolled in the carrier's jurisdiction, regardless of where the service was furnished. Suppliers billing for purchased diagnostic tests/interpretations must meet all other enrollment criteria, and must be eligible to bill for the purchased component of the test. Carriers should allow claims submitted by an IDTF for a purchased interpretation if the IDTF has previously enrolled to bill for purchased diagnostic test components it performs.

The billing physician/supplier is responsible for ensuring that the physician/supplier that furnished the purchased test/interpretation is enrolled with Medicare, and is in good standing (i.e., the physician/supplier is not sanctioned, barred, or otherwise excluded from participating in the Medicare program). The Office of Inspector General (OIG) maintains a database of information concerning parties that are excluded from participation in the Medicare, Medicare, or other Federal health programs. The OIG exclusions database is available to the public on the OIG Web site at the following address: www.oig.hhs.gov/fraud/exclusions.html. Suppliers may access this database, or use another available source, to determine whether another supplier is eligible to participate with Medicare prior to billing for a purchased diagnostic test or interpretation.

CMS will provide carriers with a national abstract file containing the HCPCS codes that are payable under the MPFS as either a purchased test or interpretation for the year, beginning in calendar year (CY) 2005. For each subsequent CY, CMS will provide carriers with a national abstract file update containing the HCPCS codes that are payable under the MPFS as a purchased test/interpretation for the upcoming year. These updates will be provided in the same format as the Medicare Physician Fee Schedule Database (MPFSDB) annual update, and will be provided as full replacement files. (See the Addendum to IOM Publication 100-04, chapter 23 for the MPFSDB record layouts by calendar year.) In addition, CMS will make quarterly updates to the abstract file to add and/or delete codes, as needed, in conjunction with the MFSDB quarterly updates.

In CY 2005, and in each year thereafter, carriers must download and install the national abstract file for purchased diagnostic tests/interpretations from the CMS Mainframe Telecommunications System. CMS will notify carriers via a change request when the file is available. This file will be made available to the carriers at approximately the same time that the annual MPFS update is released. Quarterly updates to the abstract file will be released in accordance with the schedule for the MFSDB quarterly updates. (See the Medicare Claims Processing Manual, Publication 100-04, chapter 23, section 30.6 for instructions on downloading the file.)

Carriers must use this file and any updates to price claims for purchased diagnostic services, based on the ZIP code of the location where the service was rendered. (See the IOM Publication 100-04, chapter 1, §10.1.1 for the carrier jurisdictional pricing policy.)

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.

Carriers may use their discretion in allowing payment for other purchased diagnostic services not included in the abstract file when the claim contains a ZIP code within their local jurisdiction. However, if the purchased diagnostic service claim contains an out-of-jurisdiction ZIP code, carriers must pay the claim in accordance with the abstract file. Additionally, carriers must deny an out-of-jurisdiction claim for a purchased diagnostic service when it contains a HCPCS code that is not included in the abstract file. For carrier-priced codes, carriers should use the locally developed fees for all localities.

In December 2004, CMS will issue a test abstract file for use in planning the 2005 implementation of the business rules specified in this instruction.

CMS recognizes that the abstract file for purchased diagnostic tests/interpretations may not include all diagnostic services that may be purchased. If a physician/supplier can establish that a service should be included on this file, the physician/supplier may send a note to the Division of Supplier Claims Processing in the Centers for Medicare Management, Provider Billing Group requesting that the HCPCS code be added to the abstract file in a future release.

C. Provider Education: A Medlearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn 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 must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility (place an "X" in the columns that apply)								
						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3481.1	Effective April 1, 2005, carriers shall implement a national abstract file, provided by CMS, containing the HCPCS codes that are payable under the MPFS as a purchased test or interpretation for claims with dates of service between April 1, 2005 and December 31, 2005.			X			X			
3481.2	For each calendar year (CY) after 2005, carriers shall implement a national abstract file for the HCPCS codes that are payable under the MPFS as a purchased test or interpretation for that year.			X			X			
3481.3	Upon notification, carriers shall implement quarterly updates to the national abstract file.			X			X			

Requirement Number	Requirements	Responsibility (place an "X" in the columns that apply)								
						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3481.4	Effective for claims with dates of service on or after April 1, 2005, carriers shall accept and process claims for purchased diagnostic tests/interpretations when billed by suppliers (i.e., laboratories, physicians, and IDTFs) enrolled in the carrier's jurisdiction, regardless of the location where of the service was furnished.			X						
3481.5	Carriers shall allow claims submitted by an IDTF for a purchased interpretation if the IDTF has previously enrolled to bill for purchased diagnostic test components it performs.			X						
3481.6	Effective for claims with dates of service on or after April 1, 2005, carriers shall use the national abstract file to price claims for purchased diagnostic tests/interpretations based on the ZIP code of the location where the service was rendered.			X						
3481.7	Carriers should use their discretion in allowing payment for other purchased diagnostic services not included in the abstract file when the claim contains a ZIP code within their local jurisdiction.			X						
3481.8	Carriers shall pay purchased diagnostic service claims that contain out-of-jurisdiction ZIP codes in accordance with the abstract file.			X						
3481.9	Carriers shall deny an out-of-jurisdiction claim for a purchased diagnostic service when it contains a HCPCS code that is not included in the abstract file.			X						
3481.10	For purchased diagnostic service claims submitted with carrier-priced codes, carriers shall use the locally developed fees to pay these claims, regardless of the locality.			X						
3481.11	The Common Working File shall bypass the locality edit (74x1) for specialty type 69 claims.			X						

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
3481.1-3481.11	Carriers shall use the December 2004 test file, provided by CMS, to plan the implementation of the business requirements specified in this instruction.
3481.1, 3481.2	Upon notification from CMS that the national abstract file annual update is available, carriers shall download the file from the CMS Mainframe Telecommunications via CONNECT: Direct.
3481.3	Upon notification from CMS that a quarterly update to the national abstract file is available, carriers shall download the file from the CMS Mainframe Telecommunications via CONNECT: Direct.

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements
3481.6	To establish a crosswalk between ZIP code and carrier locality, carriers must program a link between the seven-digit combination of the carrier and locality fields located in the national ZIP code file and the corresponding carrier and locality fields in 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.)

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: April 1, 2005 **Implementation Date:** April 4, 2005 **Pre-Implementation Contact(s):** Susan Webster, (410) 786-3384 **Post-Implementation Contact(s):** Susan Webster, (410) 786-3384	**Medicare contractors shall implement these instructions within their current operating budgets.**

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

Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

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(Rev. 341, 10-29-04)

10.1.1 - Payment Jurisdiction Among Local Carriers for Services Paid Under the Physician Fee Schedule and Anesthesia Services

(Rev. 341, Issued: 10-29-04, Effective: 04-01-05, Implementation: 04-04-05)

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, carriers must use the ZIP code of the location where the service was rendered to determine carrier jurisdiction over the claim and the correct payment locality.

When a physician, practitioner, or supplier furnishes physician fee schedule or anesthesia services in payment localities that span more than one carrier's service area (e.g., provider has separate offices in multiple localities and/or multiple carriers), separate claims must be submitted to the appropriate area carriers 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 carrier's service area (e.g., Indiana), the carrier which processes claims for the payment locality where the out of office service was furnished has jurisdiction for that service. It is the carrier 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 carrier 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 April 1, 2005, suppliers (including laboratories, physicians, and independent diagnostic testing facilities [IDTFs]) must bill their local carrier for all purchased diagnostic tests/interpretations, regardless of the location where the purchased service was furnished. Beginning in 2005, and in each subsequent calendar year (CY) thereafter, CMS will provide carriers with a national abstract file containing Healthcare Common Procedural Coding System (HCPCS) codes that are payable under the MPFS as either a purchased test or interpretation 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 MFSDB 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 for the supplier billing requirements applicable to purchased diagnostic services.

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 carrier 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 carrier 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-carrier state fails to specify the location where an office-based service was furnished, the carrier 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 carrier for processing. However, the specific location where the services were furnished must be entered on the claim so the carrier 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. Carriers 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.

C. Outside Carrier Jurisdiction

If carriers 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, carriers 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 carriers, 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 Purchased Services

(Rev. 341, Issued: 10-29-04, Effective: 04-01-05, Implementation: 04-04-05)

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 purchased and then billed, rather than rendered and billed by the billing entity. As for any other services, suppliers must also meet current enrollment criteria as stated in *c*hapter 10 of the Program Integrity Manual in order to be able to enroll and bill for purchased tests and interpretations. That these services are purchased does not negate the need for appropriate enrollment procedures with the carrier that has jurisdiction over the geographic area where the services were rendered. Carriers must follow the instructions in §10.1.9 if they receive claims for services outside their jurisdiction.

Effective for claim processed on or after April 1, 2004, in order to allow the carrier to determine jurisdiction, price correctly, and apply the purchase price limitations, global billing will not be accepted for purchased services on electronic or paper claims. Claims received with global billings in this situation will be treated as unprocessable per §80.3.

A - Payment Jurisdiction for Suppliers of Diagnostic Tests for Purchased Interpretations

Per §30.2.9.1, suppliers may receive payment for purchased interpretations. Effective for claims with dates of service on or after April 1, 2005, suppliers (including laboratories, physicians, and IDTFs) must submit all claims for purchased interpretations to their local carrier. Carriers must accept and process claims for purchased interpretations when billed by suppliers enrolled in the carrier's jurisdiction, regardless of the location where the service was furnished. Carriers should allow claims submitted by an IDTF for purchased interpretations if the IDTF has previously enrolled to bill for purchased diagnostic test components it performs.

B - Payment Jurisdiction for *Suppliers* for Purchased Diagnostic Tests

Per §30.2.9, *suppliers (including laboratories, physicians, and IDTFs)* may receive payment for purchased diagnostic tests. *Effective for claims with dates of service on or after April 1, 2005, suppliers must submit all claims for purchased diagnostic tests to their local carrier. Carriers must accept and process claims for purchased diagnostic tests when billed by suppliers enrolled in the carrier's jurisdiction, regardless of the location where the service was furnished.*

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

(Rev. 341, Issued: 10-29-04, Effective: 04-01-05, Implementation: 04-04-05)

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 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 April 1, 2005, carriers must accept and process all claims for purchased diagnostic tests billed by suppliers (including laboratories, physicians, and IDTFs) enrolled in the carrier's jurisdiction, regardless of the location where the service was furnished. Carriers must price the claim based on the ZIP code of the location where the service was rendered, using a CMS-supplied 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. (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. 341, Issued: 10-29-04, Effective: 04-01-05, Implementation: 04-04-05)

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 provider identification number and 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 April 1, 2005, carriers must accept and process claims for purchased diagnostic interpretations billed by suppliers (including laboratories, physicians, and IDTFs) enrolled in the carrier's jurisdiction, for services furnished anywhere in the United States. Carriers must price the claim based on the ZIP code of the location where the service was rendered, using a CMS-supplied 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. (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.*

Medicare Claims Processing Manual

Chapter 23 - Fee Schedule Administration and Coding Requirements

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(Rev. 341, 10-29-04)

30.6 - Abstract File for Purchased Diagnostic Tests/Interpretations

30.6 – Abstract File for Purchased Diagnostic Tests/Interpretations

(Rev. 341, Issued: 10-29-04, Effective: 04-01-05, Implementation: 04-04-05)

Effective April 1, 2005, CMS will provide carriers with a national abstract file containing Healthcare Common Procedural Coding System (HCPCS) codes that are payable under the MPFS as either a purchased test or interpretation for the calendar year (CY). For each subsequent CY, CMS will provide carriers with a full replacement file update to the national abstract file for use in pricing purchased diagnostic services during the upcoming year. CMS will issue a change request to notify the contractors when the file is available. (This file will be made available to the contractors for downloading when the annual Medicare Physician Fee Schedule update is released.) In addition, CMS will make quarterly updates to the abstract file to add and/or delete codes, as needed, in conjunction with the MFSDB quarterly updates.

Beginning on April 1, 2005, and in each CY thereafter, carriers must download from the CMS Mainframe Telecommunications System via CONNECT: Direct and install the national abstract file for purchased diagnostic tests/interpretations, upon notification from CMS that an update is available. Carriers must use this file to price claims for purchased diagnostic services using the ZIP code of the location where the service was furnished, in accordance with the payment rules for services paid under the MPFS provided in Internet Only Manual (IOM) Publication 100-04, chapter 1, §10.1.1.

To establish a crosswalk between the ZIP code and the carrier locality, carriers must program a link between the seven-digit combination of the carrier and locality fields located in the national ZIP code file and the corresponding fields (carrier and locality) in the abstract file for purchased diagnostic tests/interpretations.

Carriers are responsible for retrieving the purchased diagnostic service national abstract file updates upon notification. CMS will send a full-replacement file for annual updates and for any other updates that may occur. Carriers must implement the following procedure for retrieving the files:

1. *Upon receipt of the CMS CR notifying carriers that the file is available, go to the CONNECT: Direct and search for the file. Confirm that the release number (last 6 digits) corresponds to the upcoming calendar year. (For the April 2005 update, confirm that the last six digits correspond with the current calendar year.) If the release number (last six digits) does not correspond with the upcoming calendar year, notify CMS.*

2. *After confirming that the file on the CONNECT: Direct corresponds to the next calendar year, download the file and incorporate it into your testing regime for the upcoming model release.*

   The name of the file will be in the following format: ST.ZZZZZ.CCCCCLL.YYYYVV

The file will be provided in the same format as the Medicare Physician Fee Schedule File Database (MPFSDB). Refer to the MPFSDB record layout for the appropriate calendar year in the Addendum to the Medicare Claims Processing Manual, 100-04, chapter 23.