CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4473	**Date: December 6, 2019**
	Change Request 10882

SUBJECT: Update to Medicare Claims Processing Manual, Chapters 1, 23 and 35

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to revise publication 100-04, chapters 1 and 35 to include language on global billing and to separate Technical Component /Professional Component billing and update the purchased abstract file/indicator language. This update also removes obsolete language regarding Purchased Abstract File from chapter 23 (section 30.6). This update adds section 80.3.2.1.2 just to change from must to shall on one sentence and to take off PC and spell out professional component to match the rest of the language in regards to Technical and Professional components.

EFFECTIVE DATE: March 9, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: March 9, 2020

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/ 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	1/10.1.1.1/Claims Processing Instructions for Payment Jurisdiction
R	1/10.1.1.2/Payment Jurisdiction for Services Subject to the Anti-Markup Payment Limitation
R	1/30.2.9/Payment to Physician or Other Supplier for Diagnostic Tests Subject to the Anti-Markup Payment Limitation - Claims Submitted to A/B MACs (B)
R	1/80.3.2.1.2/Conditional Data Element Requirements for A/B MACs and DME MACs
D	23/30.6/Abstract File for Purchased Diagnostic Tests/Interpretations
N	35/10.2.1/Global Billing
N	35/10.2.2/Separate TC/PC Billing
R	35/30/ Diagnostic Tests Subject to the Anti-Markup Payment Limitation

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 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

Attachment - Business Requirements

Pub. 100-04	**Transmittal: 4473**	**Date: December 6, 2019**	**Change Request: 10882**

SUBJECT: Update to Medicare Claims Processing Manual, Chapters 1, 23 and 35

EFFECTIVE DATE: March 9, 2020
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I. GENERAL INFORMATION

A. Background: This CR revises publication 100-04, chapter 1 and 35 to add new sections on Global Billing and Separate Technical and Professional Component billing instructions and to update language regarding purchased abstract file, which has been replaced with a Anti-markup (Formerly Purchased Diagnostic) Test Indicator on the Medicare Physician Fee Schedule (MPFS) as of January 1, 2014. This also deletes chapter 23, section 30.6 as that information is now obsolete. More information regarding the name of the Anti-markup Test indictor is in Change Request 11191.

B. Policy: No policy changes

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	
10882.1	Contractors shall be in compliance with the updates to the CMS Internet Only Manual (IOM) publication 100-04, chapter 1- General Billing Requirements and chapter 35 - Independent Diagnostic Testing Facility (IDTF).		X							
10882.2	Contractors shall take note of the deletion of publication 100-04, chapter 23, section 30.6.	X	X							

III. PROVIDER EDUCATION TABLE

Number	**Requirement**	**Responsibility**		
		A/B MAC	DME	CED

		A	B	HHH	MAC	I
10882.3	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the “MLN Matters” listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X	X			

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
11191.2	CR 11191 :"**Medicare Physician Fee Schedule Database (MPFSDB) File Record Layout" - change of name of fields**

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

V. CONTACTS

Pre-Implementation Contact(s): Wendy Knarr, Wendy.Knarr@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

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)

Table of Contents

(Rev.4473, 12-06-19)

10.2.1 – Global billing

10.2.2 – Separate Technical and Professional Component Billing

10.1.1 - Payment Jurisdiction among A/B MACs *(Part B)* for Services Paid Under the Physician Fee Schedule and Anesthesia Services

(Rev.4473, Issued: 12-6-19; Effective: 3-9-20; Implementation: 3-9-20)

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, A/B MACs *(Part B)* must use the ZIP code of the location where the service was rendered to determine A/B MACs *(Part B)* 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, A/B MACs *(Part B)* 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 10.1.1B for instructions on processing services rendered in POS Home -12 and 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 A/B MAC *(Part B)*'s service area (e.g., provider has separate offices in multiple localities and/or multiple A/B MACs *(Part B)*), separate claims must be submitted to the appropriate area A/B MACs *(Part B)* 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 A/B MAC *(Part B)*'s service area (e.g., Indiana), the A/B MAC *(Part B)* which processes claims for the payment locality where the out of office service was furnished has jurisdiction for that service. It is the A/B MAC *(Part B)* 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 A/B MAC *(Part B)* 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 A/B MAC *(Part B)* for the *technical component and professional component* 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) *through 2013*, CMS *provided* A/B MACs *(Part B)* 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 made* quarterly updates to the abstract file to add and/or delete codes, as needed, in conjunction with the MPFSDB quarterly updates. *Beginning in 2014, CMS adopted a more streamlined approach to providing the A/B MACs with the HCPCS codes payable under the MPFS as anti-markup tests for the year. The national abstract file was discontinued and an Anti-markup (formerly Purchased Diagnostic) Test Indicator, to identify HCPCS codes payable under the MPFS as anti-markup tests for the year, was added to the MPFS payment file. Quarterly updates to the Anti-Markup Test Indicator are made directly to the MPFS Payment file.* 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 A/B MAC *(Part B)* 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 A/B MAC *(Part B)* 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 A/B MAC *(Part B)* 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 A/B MAC *(Part B)* for processing. However, the specific location where the services were furnished must be entered on the claim so the A/B MAC *(Part B)* 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. A/B MACs *(Part B)* 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. A/B MACs *(Part B)* shall take this same action for any other POS codes they currently treat as POS home.

Effective for claims processed on or after October 5, 2009, for services rendered in POS home -12, or for any other POS the contractor currently treats as POS home, when alerted by the shared system that a 9-digit ZIP code is required according to the CMS ZIP Code file, and a 9-digit ZIP code is not available on the beneficiary file, the contractor shall determine that ZIP code by using the United States Postal Service Web site. They shall use that ZIP code to determine the correct payment locality for the claim for pricing purposes.

A/B MACs *(Part B)* processing these claims shall take necessary steps to ensure that the claims for services rendered in the physical location for which they are the MAC are priced and processed correctly applying appropriate edits as necessary.

Effective January 1, 2011, for claims processed on or after January 1, 2011, using the 5010 version of the ASC X12 837 professional claim format, submission of the complete address of where the service was performed is required regardless of where the service was performed. This information should be entered on the claim per the Implementation Guide for the current version. Contractors shall use that ZIP code to determine correct payment locality.

Effective January 1, 2011 for claims processed on or after January 1, 2011 on paper claims submitted on the CMS-1500 form, submission of the ZIP code of where the service was provided will also be required for all POS code and contractors shall use that ZIP code to determine correct payment locality.

For paper and electronic claims, when a global diagnostic service code is billed (e.g. no modifier TC and no modifier 26), the address where the technical component was performed shall be reported on the claim (this only applies to global services with separate technical component/professional component). Global billing does not apply to anti-markup tests because the technical and professional component must be billed separately when the anti-markup payment limitation applies.

Refer to Pub 100-04, Chapter 35, Section 10.2.1 and 10.2.2 for more information on global billing and separate technical and professional billing.

Contractors shall make no changes for claims submitted on the 4010A1 format as they pertain to POS Home and determining pricing locality.

Contractors shall require the submission of the 9-digit ZIP code when required per the CMS ZIP Code file.

C. Outside *A/B MAC (Part B)* Jurisdiction

If A/B MACs *(Part B)* 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, A/B MACs *(Part B)* 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 A/B MACs *(Part B)*, e.g., where claims are received from physicians for dialysis and related services provided through a related dialysis facility.

10.1.1.1 - Claims Processing Instructions for Payment Jurisdiction

(Rev.4473, Issued: 12-6-19; Effective: 3-9-20; Implementation: 3-9-20)

A. Instructions for the 4010/4010A1 Version of the ASC X12 837 Professional Electronic Claim (for Claims Processed Before Implementation of Version 5010)

Note that the following instructions do not apply to services rendered at POS home -12. For services rendered at POS home – 12, use the address on the beneficiary file for the beneficiary's home (or wherever else the beneficiary information is currently being stored) to determine pricing locality. *(*See §10.1.1 for changes to processing for services rendered at POS home – 12.)

For pricing purpose, contractors shall use the ZIP code of where the service was performed. Contractors shall locate that information according to the Implementation Guide of the 4010/4010A1 version of the ASC X12 837 professional claim format.

EXCEPTION: For DME *MAC* claims - Effective for claims received on or after 1/1/05, the Standard System shall not evaluate the 2010AA loop for a valid place of service. If there is no entry in the 2420C loop or the 2310D loop, the claim shall be returned as unprocessable.

- If the Pay-To Provider Name and Address loop 2010AB is not the same as the Billing Provider, both will be entered. If the Service Facility Location loop 2310D is not the same as the Billing Provider or the Pay-To Provider, the Service Facility Location loop 2310D (claim level) will be entered. Price the service based on the ZIP code in Service Facility Location loop 2310D, unless the 2420C (line level) is also entered. In that case, price the service based on the ZIP code in the Service Facility Location loop 2420C (line level) for that line.

If the POS code is the same for all services, but the services were provided at different addresses, each service shall be submitted with the appropriate address information for each service. This will provide a ZIP code to price each service on the claim.

B. Entering the Address of Where a Service was Performed on the 5010 Version of the ASC X12 837 Professional Claim

Following the requirements of the implementation guide of the 5010 version of the ASC X12 837professional claim, the complete address of where a service was performed shall be entered. Pay the service based on the ZIP code of the address of where the service was performed based on the appropriate entry on the claim.

See §30.2.9 and Chapter 12 for information on *anti-markup* tests.

C. Paper Claims Submitted on the Form CMS-1500

Note that for claims processed on the Form CMS-1500 prior to January 1, 2011, the following instructions do not apply to services rendered at POS home – 12 or any other places of service contractors consider to be home. (See §10.1.1.1)

It is acceptable for claims to contain POS home and an additional POS code. No service address for POS home needs to be entered for the service rendered at POS home in this situation as the address will be drawn from the beneficiary file (or wherever else the A/B MAC *(Part B)* is currently storing the beneficiary information) and the information on the claim will apply to the other POS.

Except for the situation described above, the provider shall submit separate claims for each POS. The specific location where the services were furnished shall be entered on the claim. Use the ZIP code of the address entered in Item 32 to price the claim. If multiple POS codes are submitted on the same claim, treat the claim as unprocessable and follow the instructions in §80.3.1.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: M77
MSN: 9.2

Effective January 1, 2011, for claims processed on or after January 1, 2011, submitted on the Form CMS-1500 paper claim, it will no longer be acceptable for the claim to have more than one POS. Separate claims must be submitted for each POS. Contractors shall treat claims submitted with more than one POS as unprocessable and follow the instructions in §80.3.2.1.1.

If the contractor receives a fee-for-service claim containing one or more services for which the MPFS payment locality is in another A/B MAC *(Part B)*'s jurisdiction, handle in accordance with the instructions in §10.1.9. If you receive a significant volume or experience repeated incidences of misdirected Medicare Physician Fee Schedule claims/services from a particular provider, an educational contact may be warranted. Handle misdirected claims/services for HMO enrollees in accordance with §10.1.1.C and D.

D. Determining the Correct Payment Locality for Services Paid Under the Medicare Physician Fee Schedule (MPFS) and Anesthesia Services When Rendered in a Payment Locality that Crosses ZIP Code Areas

Per the instructions above, Medicare A/B MACs *(Part B)* have been directed to determine the payment locality for services paid under the MPFS and anesthesia services by using the ZIP code on the claim of where the service was performed. It has come to the attention of CMS that some ZIP codes fall into more than one payment locality. The CMS ZIP Code file uses the convention of the United States Postal Service, which assigns these ZIP codes into dominant counties. In some cases, though the service may actually be rendered in one county, per the ZIP code it is assigned into a different county. This causes a payment issue when each of the counties has a different payment locality and therefore a different payment amount. Note

that as the for services which have the Anti-markup Test Indicator on the MPFS, the 9-digit ZIP code requirements will also apply to those codes.

Effective for dates of service on or after October 1, 2007, CMS shall provide a list of the ZIP codes that cross localities as well as provide quarterly updates when necessary. The CMS ZIP Code file shall be revised to two files: one for 5-digit ZIP codes (ZIP5) and one for 9-digit ZIP codes (ZIP9). Providers performing services paid under the MPFS, anesthesia services, or any other services as described above, in those ZIP codes that cross payment localities shall be required to submit the 9-digit ZIP codes on the claim for where the service was rendered. Claims for services payable under the MPFS and anesthesia services that are NOT performed in one of the ZIP code areas that cross localities may continue to be submitted with 5-digit ZIP codes. Claims for services other than those payable under the MPFS or anesthesia services may continue to be submitted with 5-digit ZIP codes.

Beginning in 2009, contractors shall maintain separate ZIP code files for each year which will be updated on a quarterly basis. Claims shall be processed using the correct ZIP code file based on the date of service submitted on the claim.

It should be noted that though some states consist of a single pricing locality, ZIP codes can overlap states thus necessitating the submission of the 9-digit ZIP code in order to allow the process to identify the correct pricing locality.

Claims received with a 5-digit ZIP code that is one of the ZIP codes that cross localities and therefore requires a 9-digit ZIP code to be processed shall be treated as unprocessable.

For claims received that require a 9-digit ZIP code with a 4-digit extension that does not match a 4-digit extension on file, manually verify the 4-digit extension to identify a potential coding error on the claim or a new 4-digit extension established by the U.S. Postal Service (USPS). ZIP code and county information may be found at the USPS Web site at http://www.usps.com/, or other commercially available sources of ZIP code information may be consulted. If this process validates the ZIP code, the claim may be processed. The "Revision to Payment Policies *un*der the Physician Fee Schedule" that is published annually in the Federal Register, or any other available resource, may be used to determine the appropriate payment locality for the ZIP code with the new 4-digit extension. If this process does not validate the ZIP code, the claim shall be treated as unprocessable.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: MA114
MSN: N/A

Should a service be performed in a ZIP code area that does not require the submission of the 9-digit ZIP code, but the 4-digit extension has been included anyway, A/B MACs *(Part B)* shall price the claim using the A/B MAC *(Part B)* locality on the ZIP5 file and ignore the 4-digit extension.

Effective for claims processed on or after July 6, 2009, the standard system shall make revisions to allow contractors to add valid 4-digit extensions not included on the current quarter's 9-digit ZIP Code file until they appear on a quarterly file.

Contractors shall reprocess claims brought to their attention if the next CMS quarterly file is received and the locality determination on a new 4-digit extension is different than that made manually by the contractor thus having inadvertently caused incorrect payment.

E. ZIP9 Code to Locality Record Layout

Below is the ZIP9 Code to locality file layout. Information on the naming conventions, availability, how to download the ZIP5 and ZIP9 files, and the ZIP5 layout can be found in Pub. 100-04, Chapter 15, section 20.1.6.

ZIP9 Code to Locality Record Layout
(Effective for dates of service on or after October 1, 2007.)

Field Name	**Beg. Position**	**End Position**	**Length**	**Comments**
State	1	2	2	
ZIP Code	3	7	5	
A/B MAC (B)	8	12	5	
Pricing Locality	13	14	2	
Rural Indicator	15	15	1	Blank=urban R=rural B=super rural
Filler	16	20	5	
Plus Four Flag	21	21	1	0=no+4 extension 1=+4 extension
Plus Four	22	25	4	

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

(Rev.4473, Issued: 12-6-19; Effective: 3-9-20; Implementation: 3-9-20)

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 15, 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 *A/B MAC (Part B)* that has jurisdiction over the geographic area where the services were rendered.

The *A/B MAC (Part B)* must accept and process claims for services subject to the anti-markup payment limitation when billed by physicians or other suppliers enrolled in the *A/B MAC (Part B)*'s jurisdiction, regardless of the location where the services were furnished.

Effective for claims processed on or after April 1, 2004, in order to allow the *A/B MAC (Part B)* 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.

Effective for claims submitted with a receipt date on and after October 1, 2015, billing physicians and suppliers must report the name, address, and NPI of the performing physician or supplier on all anti-markup and reference laboratory claims, even if the performing physician or supplier is enrolled in a different contractor's jurisdiction. Contractors shall return as unprocessable any anti-markup or reference laboratory

claim with an NPI in Item 32a (or its electronic equivalent) that belongs to the billing physician/supplier, or that cannot be verified as a valid, Medicare enrolled entity.

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 *A/B MAC (Part B)*. *A/B MAC (Part B)* must accept and process claims for services subject to the anti-markup payment limitation when billed by suppliers enrolled in the *A/B MAC (Part B)* jurisdiction, regardless of the location where the services were furnished. *A/B MAC (Part B)* 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, *A/B MAC (Part B)* 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 *through 2013, A/B MAC (Part B)* 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. *Beginning in 2014, A/B MAC (Part B) must refer to an Anti-markup Test Indicator, to identify HCPCS codes payable under the MPFS as anti-markup tests for the year.*

30.2.9 - Payment to Physician or Other Supplier for Diagnostic Tests Subject to the Anti-Markup Payment Limitation - Claims Submitted to A/B MACs (Part B)

(Rev.4473, Issued: 12-6-19; Effective: 3-9-20; Implementation: 3-9-20)

A physician or other supplier may bill for the technical component and/or professional component of a diagnostic test that was ordered by the physician or other supplier (or ordered by a party related to the billing physician or other supplier through common ownership or control), subject to an anti-markup payment limitation, if the diagnostic test is performed by a physician who does not "share a practice" with the billing physician or other supplier. (This claim and payment limitation does not apply to clinical diagnostic laboratory tests, which are paid under the Clinical Laboratory Fee Schedule.) Under the anti-markup payment limitation, payment to the billing physician or other supplier (less the deductibles and coinsurance paid by the beneficiary or on behalf of the beneficiary) for *the technical component or professional component* of the diagnostic test may not exceed the lowest of the following amounts:

(1) The performing physician/supplier's net charge to the billing physician or other supplier.* (With respect to the *technical component,* the performing supplier is the physician who supervised the test, and with respect to the *professional component,* the performing supplier is the physician who performed the *professional component;*

(2) The billing physician or other supplier's actual charge; and

(3) The fee schedule amount for the test that would be allowed if the performing physician or other supplier billed directly. (See section 10.1.1.2 for information on payment jurisdiction for services subject to the anti-markup payment limitation.)

* 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 supplier by or through the billing physician or other supplier.

Exception to the Anti-markup Payment Limitation

If the performing physician is deemed to "share a practice" with the billing physician or other supplier (who ordered the test), the anti-markup payment limitation does not apply. A performing physician is considered to "share a practice" with the billing physician or other supplier if the performing physician furnishes

"substantially all" (at least 75 percent) of his or her professional services through the billing physician or other supplier. The "substantially all" services requirement will be satisfied, if, at the time the billing physician or other supplier submits a claim for a service furnished by the performing physician, the billing physician or other supplier has a reasonable belief that: (1) for the 12 months prior to and including the month in which the service was performed, the performing physician furnished substantially all of his or her professional services through the billing physician or other supplier; or (2) the performing physician will furnish substantially all of his or her professional services through the billing physician or other supplier for the next 12 months (including the month in which the service is performed).

If the performing physician does not meet the "substantially all" services test, the performing physician may be deemed to "share a practice" with the billing physician or other supplier if the arrangement complies with a "site of service/same building" test. This alternative approach requires the performing physician to be an owner, employer, or independent contractor of the billing physician or other supplier and requires that the *technical component or professional component* be performed "in the office of the billing physician or other supplier." The "office of the billing physician or other supplier" is any medical office space, regardless of the number of locations, in which the ordering physician or other supplier regularly furnishes patient care, and includes space where the billing physician or other supplier furnishes diagnostic testing services, if the space is located in the "same building" (as defined in 42 CFR §411.351 of the physician self-referral rules) in which the ordering physician or other ordering supplier regularly furnishes patient care. With respect to a billing physician or other supplier that is a physician organization (as defined in 42 CFR §411.351 of the physician self-referral rules), the "office of the billing physician or other supplier" is space in which the ordering physician provides substantially the full range of patient care services the ordering physician provides generally. The performance of the *technical component* includes, both, the conducting of *the technical component* as well as the supervision of the *technical component*.

The billing physician or other supplier must keep on file the name, the National Provider Identifier, and address of the performing physician. The physician or other supplier furnishing the *technical component or professional component* of the diagnostic test must be enrolled in the Medicare program. No formal reassignment is necessary.

NOTE: When billing for the *technical component or professional component* of a diagnostic test (other than a clinical diagnostic laboratory test) that is performed by another physician, the billing entity must indicate the name, address and NPI of the performing physician or other supplier in Item32 of the Form CMS-1500 claim form.

Effective for claims submitted with a receipt date on and after October 1, 2015, for reference laboratory and anti-markup claims, the billing physician or supplier must report the name, address, and NPI of the performing physician or supplier in Item 32a of the CMS-1500 claim form (or its electronic equivalent), even if the performing physician or supplier is enrolled in a different *A/B MAC (Part B)* jurisdiction. See §10.1.1.2 for more information regarding claims filing jurisdiction.

If the billing physician or other supplier performs only *the technical component or the professional component and wants to bill for both components of the diagnostic test, the TC modifier and 26 modifier* must be reported as separate line items if billing electronically (ASC X12 837 professional claim) or on separate claims if billing on paper (Form CMS-1500). Global billing is not allowed unless the billing physician or other supplier performs both components.

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

In order to have appropriate service facility location ZIP code and the acquired price of each test on the claim, when billing for anti-markup 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 anti-markup test as unprocessable per §80.3.2.

More than one anti-markup test may be billed on the ASC X12 837 professional claim format. When more than one test is billed, the total acquired amount must be submitted for each service. Treat claims received with multiple anti-markup tests without line level total acquired amount information as unprocessable per §80.3.2.

Treat paper claims submitted for anti-markup tests with both the *technical component and the professional component* 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 anti-markup test as unprocessable per §80.3.2.

ASC X12 837 professional electronic claims submitted for anti-markup tests with both the *technical component and professional component* 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 anti-markup payment limitations, global billing is not acceptable for claims received on the Form CMS-1500 or on the ASC X12 837 professional claim 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 acquired.

Effective for claims with dates of service on or after January 25, 2005, *A/B MAC (Part B)* must accept and process claims for diagnostic tests subject to the anti-markup payment limitation when billed by suppliers (including laboratories, physicians, and independent diagnostic testing facilities [IDTFs]) enrolled in the *A/B MAC (Part B)* jurisdiction, regardless of the location where the service was furnished. Effective April 1, 2005, *A/B MAC (Part B)* must price anti-markup 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 MPFS containing the HCPCS codes that are payable under the MPFS as either *a technical component or professional component* of a diagnostic test subject to the anti-markup payment limitation for the calendar year. Effective for claims with dates of service on or after October 1, 2007 *through 2013*, *A/B MAC (Part B)* must use the national abstract file to price all claims for diagnostic tests subject to an anti-markup payment limitation, for all supplier specialty types (including physicians), based on the ZIP code of the location where the service was rendered, in accordance with the *A/B MAC (Part B)* jurisdictional pricing rules specified in §10.1.1. *Beginning in 2014, A/B MAC (Part B) must refer to an Anti-markup Test Indicator linked to the HCPCS code on the MPFS to price all claims for diagnostic tests subject to an anti-markup payment limitation, for all supplier specialty types (including physicians), based on the ZIP code of the location where the service was rendered, in accordance with the A/B MAC (Part B) jurisdictional pricing rules specified in §10.1.1.*

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 anti-markup test. When a ZIP code crosses locality lines, CMS uses the dominant locality to determine the corresponding fee.

80.3.2.1.2 - Conditional Data Element Requirements for A/B MACs and DME MACs

(Rev.4473, Issued: 12-6-19; Effective: 3-9-20; Implementation: 3-9-20)

A - Universal Requirements

The following instruction describes "conditional" data element requirements, which are applicable to certain assigned A/B MAC (B) claims. This instruction is minimal and does not include all "conditional" data element requirements, which are universal for processing claims.

Items from the Form CMS-1500 claim form have been provided. These items are referred to as fields in the instruction.

A/B MACs (B) processing claims on the Form CMS-1500 *shall* return a claim as unprocessable to the supplier/provider of service in the following circumstances:

1. If a service was ordered or referred by a physician, physician assistant, nurse practitioner, or clinical nurse specialist (other than those services specified in Claim Specific Requirements) and his/her name is not present in item 17 or if the NPI is not entered in item 17b of the Form CMS-1500.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: N285 (for missing name) or N286 (for missing identifier)
MSN: N/A

2. If a physician extender or other limited licensed practitioner refers a patient for consultative services, but the name and/or NPI required of the supervising physician is not entered in items 17 or if the NPI is not entered in item 17b of the Form CMS-1500.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: N269 (for missing name) or N270 (for missing identifier)
MSN: N/A

NOTE: For item 80.3.2.1.2 -1 above, effective for claims with dates of service (DOS) on or after the implementation date of the Phase 2 ordering and referring denial edits, a Part B clinical lab and imaging technical or global component claim or Durable Medical Equipment, Prosthetics, and Orthotics Suppliers (DMEPOS) claim is denied when the ordering/referring provider not allowed to order/refer.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: 183
RARC: N574, MA13
MSN: 21.6

The claim is denied when the first four letters of the last name provided on the ordering/referring provider's claim does not match what is listed in the provider's record.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: N264, MA13, N575
MSN: 21.6

If the claim is submitted that lists an ordering/referring provider and the required matching NPI is not reported, then the claim shall be rejected. This is the only instance when a rejection is allowed.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: N265, MA13
MSN: N/A

For 3 through 12 below, the contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under these policies. These CARC/RARC combinations compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: shown below.
MSN: N/A

3. For the *technical component and professional component* of diagnostic tests subject to the anti-markup payment limitation:

   a. If a "YES" or "NO" is not indicated in item 20 and no acquisition price is entered under the word "$CHARGES." A/B MACs (B) shall assume the service is not subject to the anti-markup payment limitation. This claim shall not be returned as unprocessable for this reason only.

   b. If a "Yes" or "No" is not indicated in item 20 and an acquisition price is entered under the word "$CHARGES." RARC: MA110

   c. If the "YES" box is checked in item 20 and a required acquisition price is not entered under the word "$CHARGES." RARC: MA111

   d. If the "NO" box is checked in item 20 and an acquisition price is entered under the word "$CHARGES." RARC: MA110

   e. If the "YES" box is checked in item 20 and the acquisition price is entered under "$CHARGES", but the performing physician or other supplier's name, address, ZIP Code, and NPI is not entered into item 32a of the Form CMS-1500 when billing for diagnostic services subject to the anti-markup payment limitation. RARC: N294

   Entries f – k are effective for claims received on or after April 1, 2004:

   f. On the Form CMS-1500, if the "YES" box is checked in Item 20, and more than one test is billed on the claim;

   g. On the Form CMS-1500, if both *the technical component and professional component* are billed on the same claim and the dates of service and places of service do not match;

h. On the Form CMS-1500, if the "YES" box is checked in Item 20, both the *technical component and professional component* are submitted and the date of service and place of service codes do not match.

i. On the ASC X12 837 professional claim format, if there is an indication on the claim that a test is subject to the anti-markup payment limitation, more than one test is billed on the claim, and line level information for each total acquisition amount is not submitted for each test.

j. On the Form CMS-1500 if the "YES" box is checked in Item 20 and on the ASC X12 837 professional claim format if there is an indication on the claim that a test is subject to the anti-markup payment limitation, and the service is billed using a global code rather than having each component billed as a separate line item.

k. If there is an indication on the claim that the test is subject to anti-markup and the NPI of the performing entity (in Item 32a of the CMS-1500 or its ASC X12 837 equivalent) belongs to the billing provider OR the performing entity is not a valid, Medicare enrolled entity.

4. If a provider of service or supplier is required to submit a diagnosis in item 21 and either the diagnosis code is missing, incorrect or truncated; or a narrative diagnosis was not provided on an attachment. RARC: M76

5. For claims received on or after April 1, 2013, if a provider of service or supplier is required to submit a diagnosis in Item 21 of the Form CMS- 1500 and an ICD-9-CM "E" code (external causes of injury and poisoning) is reported in the first field of Item 21. And, effective for dates of service on or after the effective date for ICD-10-CM codes, if an ICD-10-CM diagnosis code within the code range of V00 through Y99 is reported in the first field of Item 21. RARC: MA63

   For paper claims, ICD-10-CM codes can be reported only on the revised CMS-1500 claim form version 02/12, but not before the effective date of ICD-10-CM. The revised form (02/12) has the capacity to accept either ICD-9-CM or ICD-10-CM codes depending upon the effective date of the ICD code set. The old form version (08/05) had only the capacity to accept ICD-9-CM codes. Refer to chapter 26 for more information about the old and revised forms).

6. If a rendering physician, physician assistant, nurse practitioner, clinical nurse specialist, supplier/or other practitioner who is a sole practitioner or is a member of a group practice does not enter his/her NPI into item 24J of Form CMS-1500 except for influenza virus and pneumococcal vaccine claims submitted on roster bills that do not require a rendering provider NPI. RARC: N290

7. If a primary insurer to Medicare is indicated in item 11, but items 4, 6, and 7 are incomplete. Item 4: RARC: MA92. Item 6: RARC: MA89. Item 7: RARC: MA88.

8. If there is insurance primary to Medicare that is indicated in item 11 by either an insured/group policy number or the Federal Employee Compensation Act number, but a Payer or Plan identification number (use HPID when effective) is not entered in field 11C (RARC: MA92), or the primary payer's program or plan name when a Payer or Plan ID (use HPID when effective) does not exist (RARC: N245).

9. If a HCPCS code modifier must be associated with a HCPCS procedure code or if the HCPCS code modifier is invalid or obsolete. RARC: M20

10. If a date of service extends more than 1 day and a valid "to" date is not present in item 24A. RARC: M59

11. If an "unlisted procedure code" or a "not otherwise classified" (NOC) code is indicated in item 24D, but an accompanying narrative is not present in item 19 or on an attachment. RARC: M51

12. If the name, address, and ZIP Code of the facility where the service was furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office is not entered in item 32 (Remark code MA114 is used.) Effective for claims received on or after April 1, 2004, the name, address, and ZIP Code of the service location for all services other than those furnished in place of service home – 12 must be entered. RARC: MA114

    Effective for claims with dates of service on or after October 1, 2007, the name, address, and 9-digit ZIP Code of the service location for services paid under the Medicare Physician Fee Schedule and anesthesia services, other than those furnished in place of service home – 12, and any other places of service A/B MACs treat as home, must be entered according to Pub. 100-04, Chapter 1, sections 10.1.1 and 10.1.1.1. RARC: MA114

    Effective for claims with dates of service on or after October 1, 2007, for claims received that require a 9-digit ZIP Code with a 4 digit extension, a 4-digit extension that matches one of the ZIP9 file or a 4-digit extension that can be verified according to Pub. 100-04, Chapter 1, sections 10.1.1 and 10.1.1.1 must be entered on the claim. RARC: MA114

    Effective January 1, 2011, for claims processed on or after January 1, 2011, on the Form CMS-1500, the name, address, and 5 or 9-digit ZIP code, as appropriate, of the location where the service was performed for services paid under the Medicare Physician Fee Schedule and anesthesia services, shall be entered according to Pub. 100-04, Chapter 1, sections 10.1.1 and 10.1.1.1 for services provided in all places of service. RARC: MA114

    Effective January 1, 2011, for claims processed on or after January 1, 2011, using the 5010 version of the ASC X12 837 professional electronic claim format for services payable under the MPFS and anesthesia services when rendered in POS home (or any POS they consider home) if submitted without the service facility location. RARC: MA114

13. Effective for claims received on or after April 1, 2004, if more than one name, address, and ZIP Code is entered on the Form CMS-1500 in item 32.

14. If any of the modifiers PA, PB, or PC are incorrectly associated with a service which is other than a wrong surgery on a patient, surgery on the wrong body part, surgery on the wrong patient or a service related to one of these surgical errors.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 4
RARC: N/A
MSN: N/A

10.2 - Claims Processing

(Rev.4473, Issued: 12-6-19; Effective: 3-9-20; Implementation: 3-9-20)

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. A/B MACs *(Part B)* 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 *technical component or professional component* 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., 24 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 A/B MAC *(Part B)* 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 A/B MAC *(Part B)* 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 A/B MAC *(Part B)*'s discretion. The A/B MAC *(Part B)* 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 A/B MACs *(Part B)* 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.

10.2.1 – Global Billing

(Rev.4473, Issued: 12-6-19; Effective: 3-9-20; Implementation: 3-9-20)

Global billing is acceptable when both the TC and 26 modifier are performed by the same entity and both the TC and the 26 modifier are furnished within the same Medicare Physician Fee Schedule (MPFS) payment locality. The TC and 26 may be furnished in different locations as long as they are furnished within the same MPFS payment locality.

If the global diagnostic test code is billed, report the name, address and NPI of the location where the technical component was furnished in Items 32 and 32a (or the 837P electronic claim equivalent). See Pub. 100-04, chapter 1, §80.3.2.1.2 and 80.3.2.1.3 for more information regarding what is required in Items 32 and 32a.

10.2.2 –Separate Technical and Professional Component Billing

(Rev.4473, Issued: 12-6-19; Effective: 3-9-20; Implementation: 3-9-20)

When the TC and 26 modifier are billed separately (not billed globally), report the name, address and NPI of the location where each component was performed. If the billing provider has an enrolled practice location at the address where the service was performed, the billing provider/supplier may report their own name, address and NPI in Items 32 and 32a (or the 837P electronic claim equivalent).

If the professional component service was performed at an unusual or infrequently used location, the location of the provider's/supplier's closest Medicare-enrolled practice location may be used in Item 32.

The NPI in Item 32a must correspond to the entity identified in Item 32 (no matter if it is the group, hospital, the IDTF, or the individual physician). The only exception for Medicare claims is when a service is performed out of jurisdiction and is subject to the anti-markup or a reference lab service. See Pub. 100-04, chapter 1, § 30.2.9 and chapter 16, §40.1 for instructions specific to anti-markup and reference lab, respectively.

See, Pub. 100-04, chapter 1, §80.3.2.1.2 and 80.3.2.1.3 for more information regarding what is required in Items 32 and 32a.

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

(Rev.4473, Issued: 12-6-19; Effective: 3-9-20; Implementation: 3-9-20)

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 *technical component or professional component* 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 *(Part 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 *(Part B)* jurisdiction, for services furnished anywhere in the United States. For services furnished outside the A/B MAC *(Part 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 *(Part 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. *From April 1, 2005, through December 31, 2013, this was done 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. Beginning January 1, 2014, A/B MACs (Part B) began using the Purchased Diagnostic Test Indicator for the HCPCS codes that are payable under the MPFS as an anti-markup test for the calendar year.* A/B MACs *(Part 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.

Effective for claims submitted with a receipt date on and after October 1, 2015, the billing physician or supplier must report the name, address, and NPI of the performing physician or supplier in Item 32a on anti-markup and reference laboratory claims, even if the performing physician or supplier is enrolled in a different A/B MAC *(Part B)* jurisdiction. See Pub. 100-04, Chapter 1, §10.1.1 for more information regarding claims filing jurisdiction.

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.