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Information for Medicare Fee-For-Service Health Care Professionals

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Temporary Change in Carrier Jurisdictional Pricing Rules for Purchased Diagnostic Services

Note: This article was updated on May 9, 2013, to reflect current Web addresses. This article was previously revised on May 26, 2005 to include this reference to related Change Requests CR3481 (Implementation of the Medicare Physician Fee Schedule (MPFS) National Abstract File for Purchased Diagnostic Tests and Interpretations), and CR3694 (Implementation of the Abstract File for Purchased Diagnostic Tests/Interpretations (Supplemental to CR 3481)).To see the MLN Matters article related to CR3481, go to ***http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM3481.pdf*** on the CMS website.To see the MLN Matters article related to CR3694, go to ***http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM3694.pdf*** on the CMS website.

Provider Types Affected

Physicians, laboratories, and Independent Diagnostic Testing Facilities (IDTFs)

Provider Action Needed

This instruction implements a temporary change in carrier jurisdictional pricing rules for purchased diagnostic services to allow physicians/suppliers purchasing out-of-jurisdiction diagnostic tests/interpretations to bill their local carrier for these services.

It also instructs carriers to revoke any previously issued provider identification numbers (PINs) used to allow IDTFs physically located outside of the carrier's jurisdiction to bill and be paid for purchased diagnostic tests/interpretations payable under the Medicare Physician Fee Schedule (MPFS).

Effective January 25, 2005, and until further notice, physicians/suppliers must bill their local carrier for all purchased diagnostic tests and interpretations, regardless of the location where the service was actually furnished.

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Background

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 MPFS (see the Medicare Claims Processing Manual (Pub.100-04), Chapter 1, Section 10.1.1). 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 IDTFs may bill for purchased tests and interpretations, but 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 is performed.

Since the implementation of carrier jurisdictional pricing edits on April 1, 2004, the Centers for Medicare & Medicaid Services (CMS) has received reports that, due to current enrollment restrictions, some physicians/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.

This article and related CR3630 address these reported problems by temporarily changing the carrier jurisdictional pricing rules that apply when billing for an out-of-jurisdiction area purchased diagnostic service. Carrier jurisdictional pricing rules for all other services payable under the MPFS remain in effect.

Until further notice:

- Physicians/suppliers must bill their local carrier for all purchased diagnostic tests/interpretations, regardless of the location where the service was furnished
- The billing physician/supplier must:
  - Ensure 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); and
  - Be responsible for any existing billing arrangements between the purchasing entity and the entity providing the service.

Note: The Office of Inspector General (OIG) maintains a database of information concerning parties that are excluded from participation in the Medicare, Medicaid, or other Federal health programs. The OIG exclusions database is available to the public on the OIG web site at the following address: *http://www.oig.hhs.gov/fraud/exclusions.html*. Physicians/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.

When billing for an out-of-jurisdiction purchased diagnostic service, physicians/suppliers must use their own PIN to bill for the service and must report their local facility address in the service facility location area of the claim. (For these services only, the place of service is deemed to be the billing physician's/supplier's location, rather than the location where the service was actually performed. The billing physician/supplier should use the same address reported for the portion of the service that the physician/supplier performed when reporting the address for the purchased portion of the test.)

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When submitting paper claims (form CMS-1500), physicians/suppliers billing their local carrier for a purchased test/interpretation performed outside of the carrier's jurisdiction must report their name and use their own PIN to bill both the purchased portion of the test and the portion of the test that they performed. When billing for a purchased interpretation, the billing physician/supplier should **not** report the PIN of the physician who performed the interpretation in item 19 of the claim. Instead, the billing physician/supplier must maintain a record of the name and address of the physician performing the purchased interpretation and supply it to the Medicare carrier upon request. In addition, when billing for the test/interpretation, the purchasing physician/supplier must enter the address of that portion of the service they actually performed as the address where the purchased service was preformed in block 32 of the CNMS-1500 claim form.

When submitting a claim for a purchased service on the form CMS-1500, remember that the billing physician/supplier must check box 20 "Yes" or continue to bill for the technical and professional components on separate claim forms.

When using electronic claims submissions (ANSI X12 837, version 4010A) physicians/suppliers billing for the purchased test/interpretation performed outside their carrier's jurisdiction must report their name and their PIN to bill for the purchased diagnostic service. The billing physician/supplier should continue to report the 1C qualifier (Medicare Provider Number) in the reference identification segment of the 2310C (Purchased Service Provider Secondary ID) loop.

When reporting the 2400 PS1 segment (Purchased Service Information) of the 837 format, billing physicians/suppliers must report their own PIN. The reference identifier entered in the REF02 segment of the 2310C loop must also be the PIN of the billing physician/supplier, **not** the PIN of the physician/supplier who actually performed the service.

In addition, the billing physician/supplier must enter as the service facility location the **same** address as the location where they performed the non-purchased portion of the test. Enter this address in the appropriate service facility location (Service Facility Location Loop 2310D for claim level or 2420C for the line level on the claim).

Also, a physician/supplier billing a carrier for a purchased diagnostic test must continue to report on the claim the amount that the physician/supplier charged, net of any discounts. (Independent laboratories are exempt from reporting the amount charged for purchased tests.)

When billing for a diagnostic service purchased within the local carrier's geographical service area, the physician/supplier must continue to follow existing guidelines for reporting the location where the service was furnished.

Physicians/suppliers are advised that:

- They must bill their local carrier for purchased diagnostic tests/interpretations, and they may no longer use, effective 14 days after receiving notification from the carrier, PINs issued in out-of-jurisdiction carrier sites to bill for these services; and
- They will not be penalized when they change the service facility location on the claim (even if the location reported on the claim does not correspond with the location where the service was actually performed).

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- They should not use any PINs previously issued to any supplier that is physically located outside of the carrier's jurisdiction in order for such supplier to bill and be paid for purchased diagnostic services payable under the MPFS. In particular, this includes independent clinical diagnostic laboratories [Specialty Type "69"].

Medicare carriers will accept and process claims billed by suppliers (including radiologists, physicians, and IDTFs) enrolled in the carrier's jurisdiction based on the zip code entered on the claim, regardless of where the service was actually 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.

If your carrier determines (during the claims review process) that the service was performed at a location other than the service facility address entered on the claim, the carrier must hold the physician/supplier harmless for this discrepancy, and may not deny the claim on this basis.

NOTE: For audit purposes, physicians/suppliers must maintain, and provide upon request, supporting documentation demonstrating that the test/interpretation was purchased, and documenting the location where the service was performed.

Finally, carriers will not reopen claims, but will allow physicians/suppliers to resubmit claims under this revised policy, where such claims were denied due to problems with billing out-of-jurisdiction purchased services. Such claims may be resubmitted to the local carrier for processing, but they must be filed within the time limits established for timely filing of claims.

Additional Information

For complete details, please see the official instruction issued to your carrier regarding this change. That instruction may be viewed by going to http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r415cp.pdf on the CMS website.

If you have any questions, please contact your carrier at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

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