CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1589	**Date: September 8, 2008**
	Change Request 6122

SUBJECT: Indicator for the Technical Component of Purchased Diagnostic Services

I. SUMMARY OF CHANGES: The purpose of this CR is to provide instructions to Carriers/AB MACs on how to process claims for diagnostic services when there is no entry for the Yes/No Indicator in either Block 20 of the Form CMS-1500, or if the claim does not contain either a claim or line level PS1 segment on the electronic format to indicate whether the diagnostic services were purchased. Carriers/AB MACs shall assume that the service is not purchased if there is no "Yes/No" indicator on the Form CMS-1500 or lack of claim or line level in the electronic format. Carriers/AB MACs shall adjudicate a claim lacking evidence of purchased services for a diagnostic service as if it were not a purchased service.

New / Revised Material
Effective Date: December 8, 2008
Implementation Date: December 8, 2008

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	1/80.3.2.1.2/Conditional Data Element Requirements for Carriers and DMERCs

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: 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

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1589	Date: September 8, 2008	Change Request: 6122

SUBJECT: Indicator for the Technical Component of Purchased Diagnostic Services.

Effective Date: December 8, 2008

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I. GENERAL INFORMATION

A. Background:

Effective with the implementation of the abstract file in April 2005, Carriers jurisdictional rules for purchased diagnostic tests/interpretations were 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. All purchased diagnostic services are paid under the Medicare Physician Fee Schedule (MPFS) and, therefore, are subject to the same payment rules as all other services paid under the MPFS, as well as to the jurisdictional rules for that fee schedule. Only laboratories, physicians, and independent diagnostic testing facilities (IDTF) may bill for purchased tests and interpretations.

Currently, claims for purchased diagnostic services are adjudicated in accordance with the payment limit policy specified in the IOM Publication 100-04, Chapter 16, section 40.2. When an independent laboratory, physician, and IDTF purchases the technical component (TC) of a diagnostic service, the payment amount is the lowest of the billed charge, the applicable MPFS amount, or the purchase price of the component. Medicare Carrier System is currently programmed to enforce this policy as stated in the manual.

A claim development issue sometimes arises when there is no indication whether the service was purchased. The Centers for Medicare and Medicaid Services (CMS) has found that claims have been returned as unprocessable erroneously due to the fact that the biller did not indicate whether the TC of a diagnostic service had been purchased. CMS has found over time that if there was no indication in Block 20 on the Form CMS-1500 or if the claim does not contain either a claim or line level PS1segment on the 837P X12 4010A1 electronic form, it was likely that the service had not been purchased. Thus, CMS is instituting this procedure to decrease the volume of claims returned to the physician/suppliers. Note that if there is no indication that the service was purchased and we later find that, indeed, the service had been purchased, this could result in finding of a false claim.

NOTE: A professional component (PC) service is not relevant for this policy. The purchase price of the PC portion is not and should not be a part of the adjudicative process of the technical component.

B. Policy:

Carriers/AB MACs shall assume that a diagnostic service is <u>not</u> purchased if there is no entry for the "Yes/No" indicator in either Block 20 on the Form CMS-1500 or if the claim does not contain either a claim or line level PS1segment on the electronic form, as applicable. Carriers/AB MACs shall adjudicate a claim lacking evidence of purchased service for a diagnostic service as if it were <u>not</u> a purchased service.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6122.1	When a Form CMS-1500 lacks a "Yes/No" answer in Block 20, Carriers/AB MACS shall assume a service is not purchased.	X			X						
6122.2	Carriers/AB MACs shall assume that, unless a claim contains either a claim level or line level PS1 segment in the 837P X12 4010A1 electronic format, the claim does not contain purchased services.	X			X						
6122.3	Carriers/AB MACs shall adjudicate a claim (paper and/or electronic) lacking evidence of purchased services as if it were not a purchased service.	X			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6122.4	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

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

Post-Implementation Contact(s): Your appropriate Regional Office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Carriers (RHHIs)* use only one of the following statements:

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

Section B: *For Medicare Administrative Contractors (MACs)*, use the following statement:

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.

80.3.2.1.2 - Conditional Data Element Requirements for Carriers and DMERCs

(Rev. 1589, Issued: 09-08-08, Effective: 12-08-08, Implementation: 12-08-08)

A - Universal Requirements

The following instruction describes "conditional" data element requirements, which are applicable to assigned carrier claims. This instruction is minimal and does not include all "conditional" data element requirements, which are universal for processing claims. The CMS has specified which remark code(s) should be used when a claim fails a particular "return as unprocessable" edit and a remittance advice is used to return the claim. In addition to the specified remark code(s), carriers must include Remark Code MA130 on returned claim(s). Reason code(s) must also be reported on every remittance advice used to return a claim or part of a claim as unprocessable.

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

Carriers must return a claim as unprocessable to the supplier/provider of service in the following circumstances:

a. 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 and/or NPI is not present in item 17 or 17a. or if the NPI is not entered in item 17b. of the Form CMS-1500 (8/05). (Remark code N285 or N286 is used)

b. If a physician extender or other limited licensed practitioner refers a patient for consultative services, but the name and/or NPI is required of the supervising physician is not entered in items 17 or 17a. or if the NPI is not entered in item 17b. of the CMS-1500 (8/05). (Remark code N269 or N270 is used.)

c. For diagnostic tests subject to purchase price limitations:

    1. If a "YES" or "NO" is not indicated in item 20. *Carriers/AB MACs shall assume the service is not purchased. This claim shall not be returned as unprocessable for this reason only.*

    2. If the "YES" box is checked in item 20 and *a required* purchase price is not entered under the word "$CHARGES." (Remark code MA111 is used.)

    3. If the "YES" box is checked in item 20 and the purchase price is entered under "$CHARGES", but the supplier's name, address, ZIP code, the NPI is not entered into item 32a of the Form CMS-1500 (8/05) when billing for purchased diagnostic tests. (Remark code N256, N257, or N258 are used.)

Entries 4 – 8 are effective for claims received on or after April 1, 2004:

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

5. On the Form CMS-1500, if both the interpretation and test are billed on the same claim and the dates of service and places of service do not match;

6. On the Form CMS-1500, if the "YES" box is checked in Item 20, both the interpretation and test are submitted and the date of service and place of service codes do not match.

7. On the ANSI X12N 837 electronic format, if there is an indication on the claim that a test has been purchased, more than one test is billed on the claim, and line level information for each total purchased service amount is not submitted for each test.

8. On the Form CMS-1500 if the "YES" box is checked in Item 20 and on the ANSI X12N 837 electronic format if there is an indication on the claim that a test has been purchased, and the service is billed using a global code rather than having each component billed as a separate line item.

d. If a provider of service or supplier is required to submit a diagnosis in item 21 and either an ICD-9CM code is missing, incorrect or truncated; or a narrative diagnosis was not provided on an attachment. (Remark code M81 or M76 are used.)

e. If modifiers "QB" and "QU" or, effective on or after 1/1/2006, the modifier "AQ" are entered in item 24D indicating that the service was rendered in a Health Professional Shortage Area, but where the place of service is other than the patient's home or the physician's office, the name, address, and ZIP code of the facility where the services were furnished are not entered in item 32. (Remark code MA115 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.

f. 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 NPI into item 24J of Form CMS-1500 (08-05) *except for influenza virus and pneumococcal vaccine claims submitted on roster bills that do not require a rendering provider NPI.* (Remark code *N290* is used.)

g. If a primary insurer to Medicare is indicated in item 11, but items 4, 6, and 7 are incomplete. (Remark code(s) MA64, MA88, MA89, or MA92 as appropriate for the missing piece(s) of data are used.)

h. 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 PlanID when effective) is not entered in field 11C, or the primary payer's program or plan name when a Payer or Plan ID (use PlanID when effective) does not exist. (Remark code MA92 or N245 is used.)

i. If a HCPCS code modifier must be associated with a HCPCS procedure code or if the HCPCS code modifier is invalid or obsolete. (Remark code M20 if there is a modifier but no HCPCS.)

j. If a date of service extends more than one day and a valid "to" date is not present in item 24A. (Remark code M59 is used.)

k. 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. (Remark code M51 is used.)

l. 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. (Remark code MA114 is used.)

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 contractors treat as home, must be entered according to Pub. 100-04, Chapter 1, sections 10.1.1 and 10.1.1.1. (Remark code MA114 is used.)

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. (Remark code MA114 is used.)

m. 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 *(08-05)* in item 32.