CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1987	**Date: June 11, 2010**
	Change Request 6923

SUBJECT: Correction to the Claims Processing Internet Only Manual (IOM) to Reinstate Previous Instructions Regarding Payment Jurisdiction for Reassigned Services

I. SUMMARY OF CHANGES: This CR revises Chapter 1, section 10.1.1.2, and reinstates, section 10.1.1.3 with the correct instructions regarding payment jurisdiction for reassigned services, which was deleted by CR 6627. This CR also revises the reference in Chapter 35, section 40.

EFFECTIVE DATE: August 12, 2010
IMPLEMENTATION DATE: August 12, 2010

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	1/10.1.1.2/Payment Jurisdiction for Services Subject to the Anti-Markup Payment Limitation
N	1/10.1.1.3/Payment Jurisdiction for Reassigned Services
R	35/40/Interpretations Performed Off the Premises of the IDTF

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

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: 1987	Date: June 11, 2010	Change Request: 6923

SUBJECT: Correction to the Claims Processing Internet Only Manual (IOM) to Reinstate Previous Instructions Regarding Payment Jurisdiction for Reassigned Services

Effective Date: August 12, 2010

Implementation Date: August 12, 2010

I. GENERAL INFORMATION

A. Background:

Change Requests (CR) 6627 and 6733 updated the IOM to conform to the language of the revised regulation 42 CFR §414.50 and directed contractors to take note of the change in nomenclature. Contractors were instructed to consider the term “purchased diagnostic test” to be obsolete. Contractors were instructed to instead use the nomenclature associated with the new anti-markup rule and were to implement the use of the revised language in accordance with the instructions implemented by Transmittal 445 and as reflected in the manual changes presented in CRs 6627 and 6733. These CRs implemented significant changes to Publication 100-04 which included changes made to what was formerly Chapter 1, §10.1.1.3, “Payment Jurisdiction for Reassigned Services.” Section 10.1.1.3 was moved to become a sub-part of section 10.1.1.2.

In revising this section, CMS inadvertently changed the billing instructions for reassigned services in a way that is not supported by CMS’ systems nor Medicare policy. This CR corrects this error and reinstates the instructions in place prior to the implementation of CR 6627.

B. Policy:

This CR reinstates §10.1.1.3 with the correct instructions regarding the payment jurisdiction for reassigned services. Contractors shall note the corrected language and continue to process claims accordingly. This CR also revises the reference in Chapter 35, section 40.

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	
6923.1	Contractors shall take note of the manual change presented in Pub. 100-04, Chapter 1, §10.1.1.2.	X			X						
6923.1.2	Contractors shall continue to process claims for reassigned services according to the instructions stated therein.	X			X						
6923.2	Contractors shall take note of the manual change presented in Pub. 100-04, Chapter 35, §40.	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	
6923.3	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						

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:
6923.3	CR 6627

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

V. CONTACTS

Pre-Implementation Contact(s): Felicia Rowe, felicia.rowe@cms.hhs.gov or by phone at (410) 786-5655.

Post-Implementation Contact(s): Felicia Rowe at felicia.rowe@cms.hhs.gov or by phone at (410) 786-5655.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* 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)*, include 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.

Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

Table of Contents

(Rev.1987, 06-11-10)

10.1.1.3 - Payment Jurisdiction for Reassigned Services

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

(Rev.1987, Issued: 06-11-10, Effective: 08-12-10, Implementation: 08-12-10)

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 10, 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 B/MAC that has jurisdiction over the geographic area where the services were rendered.

The B/MACs must accept and process claims for services subject to the anti-markup payment limitation when billed by physicians or other suppliers enrolled in the B/MAC's jurisdiction, regardless of the location where the services were furnished. In this instance, 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 for claims processed on or after April 1, 2004, in order to allow the B/MAC 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.

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 B/MAC. B/MACs must accept and process claims for services subject to the anti-markup payment limitation when billed by suppliers enrolled in the B/MAC's jurisdiction, regardless of the location where the services were furnished. B/MACs 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, B/MACs 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, B/MACs 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.

10.1.1.3 - Payment Jurisdiction for Reassigned Services

(Rev.1987, Issued: 06-11-10, Effective: 08-12-10, Implementation: 08-12-10)

Though a supplier or provider may reassign payment for his services to another entity, suppliers are still required to bill the correct B/MAC for reassigned services when they are paid under the MPFS. The billing entity must submit claims to the B/MAC that has jurisdiction over the geographic area where the services were rendered. Suppliers and providers must also meet current enrollment criteria stated in chapter 10 of the Program Integrity Manual in order to be able to bill for reassigned services.

Medicare Claims Processing Manual

Chapter 35 – Independent Diagnostic Testing Facility (IDTF)

40 - Interpretations Performed Off the Premises of the IDTF

(Rev.1987, Issued: 06-11-10, Effective: 08-12-10, Implementation: 08-12-10)

If an IDTF wants to bill for an interpretation performed by an independent practitioner off the premises of the IDTF, the IDTF must meet the conditions shown in IOM Pub. 100-04, §30.2.9.