CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

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CHANGE REQUEST 2631

I. SUMMARY OF CHANGES: This change request includes some necessary minor revisions due to the incorrect transference of the material from the paper based Medicare Carriers Manual to the Internet Only Manual in Chapter 1, Section 10, Jurisdiction for Claims. The title of section 10.1.1 is revised to better reflect the contents of the section. Some additional revisions have been made to clarify the section. Parts A and B of section 10.1.1.3 are deleted as they are duplicative of parts A and B of 10.1.1.2. Section 10.1.2 is deleted as it is duplicative of section 10.1.1.A. The cross reference in the first paragraph of section 30.2.9 is revised to reflect an IOM reference.

MANUALIZATION - EFFECTIVE DATE: N/A
***IMPLEMENTATION DATE: N/A**

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	1/Table of Contents
R	1/10.1.1/Payment Jurisdiction Among Local Carriers for Services Paid Under the Physician Fee Schedule and Anesthesia Services
R	1/10.1.1.3/Payment Jurisdiction for Reassigned Services
D	1/10.1.2/Physician, Supplier, and Group Practice Billing for Multiple Locations
R	1/30.2.9/Payment to Physician for Purchased Diagnostic Tests - Claims Submitted to Carriers

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

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

***Medicare contractors only**

Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

Table of Contents

(Rev. 169, 05-07-04)

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

(Rev. 169, 05-07-04)

B3-3100.1, B3-3101, B4 2010 partial, B3-4267, R1813B3

The jurisdiction for processing a request for payment for services paid under the Medicare Physician Fee Schedule (MPFS) and for anesthesia services is governed by the payment locality where the service is furnished and will be based on the ZIP code. Though a number of additional services appear on the MPFS database, these payment jurisdiction rules apply only to those services actually paid under the MPFS and to anesthesia services. (For example, it does not apply to clinical lab, ambulance or drug claims.)

Effective for claims received on or after April 1, 2004, carriers must use the ZIP code of the location where the service was rendered to determine carrier jurisdiction over the claim and the correct payment locality.

When a physician, practitioner, or supplier furnishes physician fee schedule *or anesthesia* services in payment localities that span more than one carrier's service area (e.g., provider has separate offices in multiple localities and/or multiple carriers), separate claims must be submitted to the appropriate area carriers for processing. For example, when a physician with an office in Illinois furnishes services outside the office setting (e.g., home, hospital, SNF visits) and that out-of-office service location is in another carrier's service area (e.g., Indiana), the carrier which processes claims for the payment locality where the out of office service was furnished has jurisdiction for that service. It is the carrier with the correct physician fee schedule pricing data for the location where the service was furnished. In the majority of cases, the physician fee schedule *or anesthesia* services provided by physicians are within the same carrier jurisdiction that the physicians' office(s)is/are located.

A. Multiple Offices

In states with multiple physician fee schedule pricing localities or where a provider has multiple offices located in two or more states, or there is more than one carrier servicing a particular state, physicians, suppliers and group practices with multiple offices in such areas must identify the specific location where office-based services were performed. This is to insure correct claim processing jurisdiction and/or correct pricing of MPFS *and anesthesia* services. The carrier must ensure that multiple office situations are cross-referenced within its system. If a physician/group with offices in more than one MPFS pricing locality or a multi-carrier state fails to specify the location where an office-based service was furnished, the carrier will return/reject the claim as unprocessable.

Physicians, suppliers, and group practices that furnish physician fee schedule services at more than one office/practice location may submit their claims through one office to the carrier for processing. However, the specific location where the services were furnished

must be entered on the claim so the carrier has the ZIP code, can determine the correct claims processing jurisdiction, and can apply the correct physician fee schedule amount.

B. ***Service Provided at a Place of Service Other than Home-12 or Office-11***

For claims submitted prior to April 1, 2004, in order to determine claims jurisdiction, Medicare approved charges, Medicare payment amounts, Medicare limiting charges and beneficiary liability, Part B fee-for-service claims for services furnished in other than in an office setting or a beneficiary's home must include information specifying where the service was provided.

Effective for claims received on or after April 1, 2004, claims for services furnished in all places of service other than a beneficiary's home must include information specifying where the service was provided. Carriers must use the address on the beneficiary files when place of service (POS) is home - 12, or any other mechanism currently in place to determine pricing locality when POS is home – 12.

C. Outside Carrier Jurisdiction

If carriers receive claims outside of their jurisdiction, they must follow resolution procedures in accordance with the instructions in 10.1.9. If they receive a significant volume or experiences repeated incidences of misdirected Medicare Physician Fee Schedule *or anesthesia* services from a particular provider, an educational contact may be warranted.

D. HMO Claims

For services that HMOs are not required to furnish, carriers process claims for items or services provided to an HMO member over which they have jurisdiction in the same manner as they process other Part B claims for items or services provided by physicians or suppliers. Generally, the physician/supplier who provides in-plan services to its HMO members submits a bill directly to the HMO for payment and normally does not get involved in processing the claim. However, in some cases, claims for services to HMO members are also submitted to carriers, e.g., where claims are received from physicians for dialysis and related services provided through a related dialysis facility.

10.1.1.3 - Payment Jurisdiction for Reassigned Services

(Rev. 169, 05-07-04)

Though a supplier or provider may reassign payment for his services to another entity; that does not negate the necessity of billing the correct carrier for those services when they are services paid under the MPFS. The entity that will be billing for the services must still bill the carrier that has jurisdiction over the geographic area where the services were rendered. suppliers and providers must also meet current enrollment criteria as stated in chapter 10 of the Program Integrity Manual in order to be able to enroll and bill for reassigned services.

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

(Rev. 169, 05-07-04)

B3-3060.4, R1813B3

A physician or a medical group may submit the claim and (if assignment is accepted) receive the Part B payment, for the **technical component** of diagnostic tests which the physician or group purchases from an independent physician, medical group, or other supplier. (This claim and payment procedure does not extend to clinical diagnostic laboratory tests.) The purchasing physician or group may be the same physician or group as ordered the tests or may be a different physician or group. An example of the latter situation is when the attending physician orders radiology tests from a radiologist and the radiologist purchases the tests from an imaging center. The purchasing physician or group may not markup the charge for a test from the purchase price and must accept the lowest of the fee schedule amount if the supplier had billed directly; the physician's actual charge; or the supplier's net charge to the purchasing physician or group, as full payment for the test even if assignment is not accepted. (See *section 10.1.1.2* for additional information on purchased diagnostic tests.)

In order to purchase a diagnostic test, the purchaser must perform the interpretation. The physician or other supplier that furnished the technical component must be enrolled in the Medicare program. No formal reassignment is necessary.

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

- In order to have appropriate service facility location ZIP code and the purchase price of each test on the claim, when billing for purchased tests on the Form CMS-1500 paper claim form each test must be submitted on a separate claim form. Treat paper claims submitted with more than one purchased test as unprocessable per §80.3.2.

- More than one purchased test may be billed on the ANSI X12N 837 electronic format. When more than one test is billed, the total purchased service amount must be submitted for each service. Treat claims received with multiple purchased tests without line level total purchased service amount information as unprocessable per §80.3.2.

- Treat paper claims submitted for purchased services with both the interpretation and the purchased test on one claim as unprocessable per §80.3.2 unless the services are submitted with the same date of service and same place of service codes. When a claim is received that includes both services, and the date of service and place of service codes match, assume that the one address in Item 32 applies to both services.

- ANSI X12N 837 electronic claims submitted for purchased services with both the interpretation and purchased test on the same claim must be accepted. Assume that the claim level service facility location information applies to both services if line level information is not provided.

- In order to price claims correctly and apply purchase price limitations, global billing is not acceptable for claims received on the Form CMS-1500 or on the ANSI X12N 837 electronic format. Each component must be billed as a separate line item (or on a separate claim per the limitations described above). Treat the claim as unprocessable per §80.3.2 when a global billing is received and there is information on the claim that indicates the test was purchased.