CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 67 **Date: JANUARY 16, 2004**

CHANGE REQUEST 3039

I. SUMMARY OF CHANGES: Carriers and standard systems will not be required to make any changes in how they require claims in the National Standard Format (NSF) to be submitted or how they process claims received for services in the NSF format for services paid under the Medicare Physician Fee Schedule and anesthesia services that are subject to jurisdictional pricing.

NEW/REVISED MATERIAL - EFFECTIVE DATE: April 1, 2004
***IMPLEMENTATION DATE: April 5, 2004**

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.

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

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	1/10.1.1.1 - Claims Processing Instructions for Payment Jurisdiction for Claims Received on or After April 1, 2004
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:

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

***Medicare contractors only**

Attachment - Business Requirements

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SUBJECT: Revision to CR 2912: Coding, Testing, and Implementation Phases of CR 2631 for Jurisdiction

I. GENERAL INFORMATION

A. Background: CR 2912 required carriers and standard systems to make changes to the National Standard Format (NSF) in order to implement jurisdictional pricing for services paid under the Medicare Physician Fee Schedule and anesthesia services. It has been determined that requiring changes to the NSF format would cause too great an impact on providers, carriers, and standard systems to justify making the changes as the format will no longer be valid in the near future. This CR removes that requirement and requires additional provider education.

B. Policy: N/A

C. Provider Education: Carriers shall inform affected providers by posting either a summary or relevant portions of this document on their Web site within two weeks or at the same time they post information as required by CR 2912. Also, carriers shall publish this same information in their next regularly scheduled bulletin. If they have a listserv that targets affected providers, they shall use it to notify subscribers that information about jurisdictional pricing is available on their Web site.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
3039.1	Carriers and standard systems shall continue to accept and process claims for services paid under the Medicare Physician Fee Schedule and anesthesia services subject to jurisdictional pricing received in the NSF format as they have accepted and processed them prior to the planned implementation of CR 2912.	Carriers, VIPS and MCS
3039.2	Carriers shall notify providers through the methods described in section I.C above that no changes in the submission of claims in the NSF format will be required for jurisdictional pricing for services paid under the Medicare Physician Fee Schedule and anesthesia services.	Carriers
3039.2.1	Carriers will continue with the provider education efforts described in CR 2912.	Carriers

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: April 1, 2004 **Implementation Date: April 5, 2004** **Pre-Implementation Contact(s): Appropriate Regional Office.** **Post-Implementation Contact(s): Appropriate Regional Office.**	**These instructions shall be implemented within your current operating budget.**

10.1.1.1 - Claims Processing Instructions for Payment Jurisdiction for Claims Received on or after April 1, 2004

(Rev. 67, 01-16-04)

Provided below are separate instructions for processing electronic *claims using the ANSI X12N 837 format* and paper claims. *No changes will be required in either submission or processing for claims for services subject to jurisdictional pricing for services paid under the Medicare physician fee schedule and anesthesia services submitted on the National Standard Format.* See §30.2.9 and Chapter 12 for additional information on purchased tests.

A - *ANSI X12N 837* Electronic Claims

Please 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 (or wherever else the beneficiary information is currently being stored) to determine pricing locality. (See §10.1.1.)

Per the implementation guide of the 4010/4010A1 version of the ANSI X12N 837, it is acceptable for claims to contain the code for POS home and any number of additional POS codes. If different POS codes are used for services on the claim, a corresponding service facility location and address must be entered for each service at the line level, if that location is different from the billing provider, pay-to-provider, or claim level service facility location. Pay the service based on the ZIP code of the service facility location, billing provider address, or pay-to provider address depending upon which information is provided.

Refer to the current implementation guide of the ANSI X12N 837 to determine how information concerning where a service was rendered, the service facility location, must be entered on a claim. Per the documentation, though an address may not appear in the loop named "service facility address," the information may still be available on the claim in a related loop.

For example:

- On version 4010/4010A of the ANSI X12N 837 electronic claim format, the Billing Provider loop 2010AA is required and therefore must always be entered. If the Pay-To Provider Name and Address loop 2010AB is the same as the Billing Provider, only the Billing Provider will be entered. If no Pay-To Provider Name and Address is entered in loop 2010AB, and the Service Facility Location loop 2310D (claim level) or 2420C (line level) is the same as the Billing Provider, then only the Billing Provider will be entered. In this case, price the service based on the Billing Provider ZIP code.

- 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.

Make any necessary accommodations in claims processing systems to accept either the header level or line level information as appropriate and process the claims accordingly. No longer use the provider address on file when the POS is office to determine pricing locality and jurisdiction. Appropriate information from the claim must always be used.

In the following situation, per the information in the 4010/4010A1 version of the ANSI X12N 837, the place where the service was rendered cannot be identified from the claim. In this situation, price all services on the claim based on the ZIP code in the Billing Provider loop. Continue to take this action until such time as the ASC documentation is revised to allow for identification of where the service was rendered to be identified from the claim.

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 (claim level) or 2420C (line level) is the same as the Billing Provider or the Pay-To Provider, no entry is required per version 4010/4010A1 for Service Facility Location loop 2310D (claim level) or 2420C (line level).

When the same POS code and same service location address is applicable to each service line on the claim, the service facility location name and address must be entered at the claim level loop 2310D.

In general, when the service facility location name and address is entered only at the claim level, use the ZIP code of that address to determine pricing locality for each of the services on the claim. When entered at the line level, the ZIP code for each line must be used.

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

B - Paper Claims Submitted on the Form CMS-1500

Note that the following instructions do not apply to services rendered at POS home - 12. (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 carrier is currently storing the beneficiary information) and the information on the claim will apply to the other POS.

The provider must submit separate claims for each POS. The specific location where the services were furnished must 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 assigned claims as unprocessable and follow the instructions in §§80.3.1. Carriers must continue to follow their current procedures for handling unprocessable unassigned claims.

Use the following messages:

> Remittance Advice – Adjustment Reason Code 16 – Claims/service lacks information that is needed for adjudication, and Remark Code –M77 – "Incomplete/invalid place of service(s)."
>
> MSN - 9.2 - "This item or service was denied because information required to make payment was missing."

If the contractor receives a fee-for-service claim containing one or more services for which the MPFS payment locality is in another carrier'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.

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

(Rev. 67, 01-16-04)

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 Chapter 12 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, per Chapter 26 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.

- *No changes will be required in either submission or processing for claims for services paid under the Medicare physician fee schedule and anesthesia services subject to jurisdictional pricing submitted on the National Standard Format.*

Refer to Chapter 16 for more information.