Business Requirements

Pub.100-04 Chap.16 §40.2	Transmittal: 16	Date: October 31, 2003	Change Request 2919

I. GENERAL INFORMATION

A. Background: Currently claims for purchased diagnostic services are adjudicated based on a policy established in the paper based Medicare Carriers Manual (MCM). The former paper based MCM §15048 states that "If a physician or laboratory bills for a laboratory test performed by an outside supplier, the fee schedule amount for the purchased service equals the lower of the billing physician's/laboratory's fee schedule or the price paid for the service." This means we paid the lower of the fee schedule or the purchase price or the submitted charge of the purchased technical component for both physician and Independent Laboratory claims. The physician/supplier had to identify the supplier providing the technical component.

The carrier shared systems are currently programmed to enforce this policy as stated in the old manuals. The updated Internet Only Manual has changed this policy to state that the payment rule applies only to physicians.

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

B. Policy: Publication 100-04 Chapter 1 §30.2.9; Payment to Physician for Purchased Diagnostic Tests - Claims Submitted to Carriers, states "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."

A new policy is being added to Publication 100-04 Chapter 16 §40.2 that clarifies that when an independent laboratory bills for a laboratory test performed by an outside supplier, the payment amount for the purchased service is based on the lower of the submitted charge or the fee on the Medicare Physician Fee Schedule (MPFS)." The independent laboratory must perform at least one of the services billed. If the service being billed is the professional component of a test, the independent laboratory must meet the rules of Publication 100-04 Chapter 1 §30.2.6.

Purchased diagnostic tests are paid using the MPFS, thus, the jurisdiction rules for the MPFS apply.

C. Provider Education: Carriers shall inform affected providers by posting either a summary or relevant portions of this document on their Web site within one month. 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 an independent laboratory's billing of purchased diagnostic tests is available on their Web site.

II. BUSINESS REQUIREMENTS

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

Requirement #	Requirements	Responsibility
1	Independent Laboratories shall receive the lower of the submitted charge or the fee schedule amount for the technical component of purchased diagnostic tests no matter where the service was purchased.	Shared System Maintainer and Carrier
2	Claims jurisdiction is based on where the service is performed.	Shared System Maintainer and Carrier
3	A purchased diagnostic test submitted by an independent laboratory (specialty 69) shall not be subject to a payment edit requiring an amount in item 20 on the CMS-1500, field FB0-05.0 on the National Standard Format and Loop 2400 data element PS102 on the X12 4010A1 electronic format.	Shared System Maintainer and Carrier
4	Claims that are submitted with a CPT modifier 90 on the claim and the service is not a clinical diagnostic laboratory service payable under the clinical diagnostic laboratory fee schedule or is indicated as reimbursed under the reasonable charge payment methodology in the "**Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment Method"** should be returned as unprocessable	Shared System Maintainer and Carrier

II. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	**Instructions**
MCM Part 3 §3060.4	Transmittal 1813, CR 2631

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements
N/A	

C. Interfaces: N/A

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

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. OTHER CHANGES

Citation	Change
N/A	

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: April 1, 2004 **Implementation Date: April 5, 2004** **Pre-Implementation Contact(s):** **Dan Layne dlayne@cms.hhs.gov** **(410)786-3320** **Post-Implementation Contact(s):** **The appropriate Regional Office**	**These instructions should be implemented within your current operating budget.**