Medicare
Carriers Manual
Part 3 - Claims Process

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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CHANGE REQUEST 1474

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3045.6 – 3045.6 (Cont.)	3-36.3 – 3-36.4 (2 pp.)	3-36.3 – 3-36.4 (2 pp.)

CORRECTION--*EFFECTIVE DATE: February 1, 2001*
IMPLEMENTATION DATE: February 1, 2001

Section 3045.6, Physicians Billing for Purchased Diagnostic Tests (Other Than Clinical Diagnostic Laboratory Tests, is revised to reflect the correct statutory cite (§1842(n)(3) of the Act) for carriers to use in their communications with providers.

These instructions should be implemented within your current operating budget.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previous published in the manual and is only being reprinted.

3045.5 Mandatory Assignment Requirement for Physician Office Laboratories.--

A. General.--No payment may be made for clinical diagnostic laboratory tests furnished by a physician or medical group unless the physician or medical group accepts assignment or claims payment under the indirect payment procedure in §7065. If assignment is accepted for a covered test, pay the lesser of the fee schedule amount or the actual charge. (See §5114.) If payment is made under §7065, unmet deductible and coinsurance are applicable.

Direct payment to a physician or group after the death of the beneficiary is considered assigned payment. Assignment may be accepted for the entire claim. See subsections B. and C. if a physician wishes to accept assignment only for laboratory services.

B. Submission of Non-EMC Claims.--A nonparticipating physician or medical group who furnishes clinical diagnostic laboratory tests and other services to a beneficiary and accepts assignment only for the laboratory tests may either submit a separate (assigned) claim for them or a single claim that includes both the assigned tests and the other unassigned services. In the latter event, the claim must be annotated as unassigned in block 26 of the HCFA-1500 and a special request for payment for the assigned tests written in block 25, as follows: "I accept assignment for the clinical laboratory tests."

C. Submission of EMC Claims.--A nonparticipating EMC physician or medical group who furnishes clinical diagnostic laboratory tests and other services and accepts assignment only for the laboratory tests may either submit a separate (assigned) data set for the tests or a single data set that includes both the assigned tests and the unassigned other services. In the latter event, the data set must include the unassigned indicator. The physician or group must have filed a blanket statement agreeing to accept assignment on all clinical diagnostic laboratory tests, not withstanding the inclusion of the unassigned indicator on electronic data sets.

D. Processing Claims.--Process as assigned all claims for clinical diagnostic laboratory tests as described above, including those submitted by a participating or non-participating physician or group either marked as unassigned or with no assignment option specified. Where, however, evidence clearly shows that the beneficiary or provider refuses to assign the claim, deny it. (See §§3040.3 and 3040.4.) Split a claim containing assigned laboratory tests and other unassigned services. (See §3000.1.)

E. Public Information.--Inform all physicians and medical groups of this policy annually.

3045.6 Physicians Billing for Purchased Diagnostic Tests (Other Than Clinical Diagnostic Laboratory Tests).--

A. General.--Effective April 1, 1988, a physician may not mark up purchased diagnostic tests. If a physician's bill or a request for payment includes a charge for a diagnostic test (other than a clinical diagnostic laboratory test) which the physician did not personally perform or supervise, payment for the test may not exceed the lesser of:

- The actual acquisition cost (net any discounts); or
- The lower of the supplier's reasonable charge for the test.

For payment to be made, the physician who purchases a test from an outside source must identify the supplier, the supplier's provider number and the amount the supplier charged. No payment may be made to the physician without this information unless the statement "No purchased tests are included" is annotated on the claim. (See §4032.2.)

B. Unassigned Claims with Required Documentation--A physician may not bill an individual an amount in excess of Medicare's payment, except for any deductible and coinsurance, for a purchased diagnostic test. Notify physicians to indicate when a diagnostic test was purchased, identify the supplier, and show the amount the supplier charged. Include in the notification that they are prohibited by §1842(n)(3) of the Act from billing or collecting an amount in excess of Medicare's payment, except for the deductible and coinsurance. Excess amounts collected from the beneficiary must be repaid.

C. Unassigned Claims without Required Documentation--A physician may not bill a beneficiary:

- If the bill does not indicate who performed the test; and
- If the bill indicates that the test was performed by a supplier, it does not identify the supplier or does not include the amount it charged.

Notify the physician when a non-assigned claim for purchased services is received from either the physician or a beneficiary except when the physician submits an assigned claim and the beneficiary submits an unassigned duplicate claim. Use the following sample letter.

Dear Doctor:

We have received an unassigned claim for diagnostic tests furnished to your patient (Beneficiary Name), on (Date of Service). You are prohibited by §1842(n)(3) of the Social Security Act from billing or collecting any amount unless you indicate that "No purchased services are included" or, if the diagnostic test was purchased, you indicate who performed the test and what the supplier charged you. Some or all of the required information is missing from your patient's claim. If you have collected any amount from your patient, it must be refunded. This claim may be resubmitted if the required information is included.