# Medicare
# Carriers Manual
## Part 3 - Claims Process

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

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**CHANGE REQUEST 1658**

| HEADER SECTION NUMBERS | PAGES TO INSERT | PAGES TO DELETE |
|---|---|---|
| Table of Contents – Chapter 3 | 3-1.2 – 3-2 (2 pp.) | 3-1.2 – 3-2 (2 pp.) |
| 3060.3 (Cont.) – 3060.3 (Cont.) | 3-51 – 3-52 (2 pp.) | 3-51 – 3-52 (2 pp.) |
| 3101 – 3101 (Cont.) | 3-61 – 3-62 (2 pp.) | 3-61 – 3-62 (2 pp.) |
| 3110 – 3116 | 3-67 – 3-69 (3 pp.) | 3-67 – 3-70.3 (7 pp.) |
| 4020.2 (Cont.) – 4020.2 (Cont.) | 4-20.5 – 4-20.6 (2 pp.) | 4-20.5 – 4-20.6 (2 pp.) |
| 15048 – 15048 (Cont.) | 15-45 – 15-45.1 2 pp.) | 15-45 – 15-45.1 (2 pp.) |

**NEW/REVISED MATERIAL--*EFFECTIVE DATE: October 1, 2002***
***IMPLEMENTATION DATE: October 1, 2002***

Section 3060.5, Payment to Supplier of Diagnostic Tests for Purchased Interpretations, revises the requirement that the entity providing the test and purchasing the interpretation has to submit the claims for both components in order for the carrier to pay for the purchased interpretation. Any edits that require that both components must be billed in order to pay for the purchased interpretation must be adjusted to allow purchased interpretations to be payable for claims with dates of service on or after April 1, 2001. Carriers need not search their files for previously denied claims. However, carriers must adjust claims brought to their attention.

**NOTE: The change to §3060.5 does not negate the requirement in that section or in §3060.4 that when an entity either purchases an interpretation or a test, they themselves must perform the other component in order to be paid for the purchased component.**

Section 3101, Area Carrier – Physician's Services, revises and incorporates what was previously subsection B into subsection A. The sentence concerning the assignment of provider identification numbers (PINs) to each office location has been revised to clarify that the assignment of PINs to separate office locations within a carrier's service area is at the carrier's discretion. This section also includes clarification concerning the enrollment of providers with no office location within a carrier's jurisdiction, and a clarification about the number and type of place of service codes that can be submitted on one claim.

Section 3110, Transferring Requests for Medicare Payment, is deleted and a new section, Section 3110, Disposition of Misdirected Claims is included. This section instructs carriers to return misdirected claims to the sender rather than to forward them.

Section 4020.2, Items 14-33 - Physician or Supplier Information, is revised to no longer allow "SAME" to be entered in Item 32 when the address is the same as in Item 33. It is also revised to include instructions on how to dispose of foreign claims that will not include zip code information.

Section 15048, Purchased Diagnostic Tests, is revised to coordinate with a prior change to §2070, which removed the reference to diagnostic tests being furnished as "incident to" services. Language has also been added concerning questionable business arrangements.

**NOTE: Standard systems and contractors are to implement only those items shown in redline and are not to implement any other pre-existing provisions of the MCM for which they have a waiver in effect.**

**CMS-Pub.14-3**

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

**These instructions should be implemented within your current operating budget.**

CHAPTER III
CLAIMS, FILING, JURISDICTION
AND DEVELOPMENT PROCEDURES

Section

## Medicare Standard Systems



## Jurisdiction of Claims



## Parenteral and Enteral Nutrition



## Claim Number



## Claims Development Procedures and Situations

CHAPTER III
CLAIMS, FILING, JURISDICTION
AND DEVELOPMENT PROCEDURES

3. Physicians of the faculty practice plan are employees of the University and/or medical school. The plan should furnish a copy of the employment agreement(s) between the faculty physician and the University.

4. Physicians are full or part-time faculty members of the University's School of Medicine, licensed to practice medicine in the State.

5. The faculty practice plan may only be affiliated with one University, and this relationship is described in the written agreement between the University and the Medical Faculty Practice Plan.

6. Members of the faculty practice plan are represented on the Governing Board of the practice plan. The Board has the authority to make or delegate management and operational decisions on behalf of the physicians participating in the practice plan.

7. Faculty practice plan physicians have unrestricted access to the billing records, medical documentation, and claims forms for services submitted on their behalf by the practice plan. The faculty practice plan provides documentation establishing the existence of this policy.

8. The physicians abide by the rules and regulations of the Medical Faculty Practice Plan.

9. The faculty practice plan is accountable to Medicare for any claims that are submitted on behalf of the plan's physicians for services provided to Medicare beneficiaries. Thus, the plan is responsible for refunding any overpayments to Medicare that are collected on behalf of the plan's physicians.

Both the Medical Faculty Practice Plan and the plan's physicians must enroll in the Medicare program by completing the Form HCFA-855 and Form HCFA-855R (Medicare health care provider/supplier enrollment application forms). Instructions for processing Form HCFA-855 are referenced in Part IV, §1030 of the Medicare Carriers Manual.

For those entities that are part of the organizational structure of the University, see §3060.8B of the Medicare Carriers Manual, on payment to special accounts. These entities may include departments, specialties, practice plans, or similar subdivisions of a university or medical school.

E. Managed Care Organizations, including HCPPs, cost-contracting HMOs, CMPs, and Medicare + Choice Organizations.--Carriers may make reassigned Part B payments under limited circumstances to HCPPs, cost-contracting HMOs, CMPs, and to Medicare + Choice Organizations.

A Medicare + Choice Organization is an entity that meets the following criteria: (1) Is a public or private entity licensed by a state as a risk-bearing entity (with the exception of a provider-sponsored organization receiving a Federal waiver from state licensure requirements) that is certified by HCFA as meeting the Medicare + Choice contract requirements; (2) Is responsible for the organization, financing, administration, and contracting for the delivery of covered Part A and Part B services on a prepayment arrangement basis (HCPP agreements are only for Part B services); and, (3) Arranges for the provision of Medicare + Choice plan(s) (health benefits coverage offered under a policy or contract) services to enrolled Medicare beneficiaries residing in the service area of the Medicare + Choice plan(s).

The following are circumstances under which payments may be made by a carrier to an HCPP, a cost-contracting HMO, a CMP, or a Medicare + Choice Organization:

1. The services are furnished to a beneficiary who is not a Medicare enrollee of the HCPP, HMO, or CMP, or Medicare + Choice Organization;

2. The services are furnished to a beneficiary who is a Medicare enrollee of the HCPP, HMO, CMP, or Medicare + Choice Organization, but who has not been added to CMS rolls as such;

3. The services are furnished to a beneficiary who is a Medicare enrollee of an HCPP, cost-contracting HMO, or CMP, but the services must be billed to the carrier because they are subject to certain administrative billing restrictions, e.g., independent physical therapy, blood, and end stage renal disease services;

4. The services, in the nature of attending physician services or services unrelated to a terminal illness, are furnished to a Medicare enrollee of a Medicare + Choice Organization who has elected the hospice benefit; or,

5. The services are furnished by a Medicare + Choice Organization to a Medicare enrollee, but are excluded from it's Medicare + Choice contract under §1852(a)(5) of the Social Security Act.

When an HCPP, HMO, CMP, or Medicare + Choice Organization pays the physician, medical group, or other supplier on a fee-for-service basis, and conditions 2, 3, or 4 above are met, it may claim and receive payment from the carrier for the services under the indirect payment procedure (see §7065) if it is approved as a qualified organization under that section and the other conditions for payment under §7065 are met.

3060.4 Payment to Physician for Purchased Diagnostic Tests.--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 §15048.)

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.

3060.5 Payment to Supplier of Diagnostic Tests for Purchased Interpretations. A person or entity that provides diagnostic tests may submit the claim, and (if assignment is accepted) receive the Part B payment, for diagnostic test interpretations which that person or entity purchases from an independent physician or medical group if:

o The tests are initiated by a physician or medical group which is independent of the person or entity providing the tests and of the physician or medical group providing the interpretations;

Jurisdiction of Claims

## 3100. JURISDICTION OF REQUESTS FOR PAYMENT

Medicare carriers typically process Part B fee-for-service claims for covered services furnished in specific geographic areas (e.g., Florida) or for particular Medicare enrollees (e.g., railroad retirement beneficiaries), or for specific types of covered services (e.g., Durable Medical Equipment). (See §2312.3 for claims for Part B medical services performed outside the U.S., for individuals who reside in the U.S.) The rules for determining jurisdiction are the same whether a claim is assigned or nonassigned.

Since the status of a qualified railroad retirement beneficiary may change, carrier jurisdiction may also change. When a carrier receives a Common Working File (CWF) response showing it has jurisdiction but a later CWF response shows that the railroad carrier now has jurisdiction (code 46), the carrier should follow the instructions in §3110. This is true even when the carrier originally receiving the claim may have reason to believe that the jurisdiction has changed again. When a change in jurisdiction occurs, CMS will automatically notify the local and railroad carrier of the change. See §6130.2 for further information involving qualified railroad retirement beneficiaries.

A nonparticipating skilled nursing facility (SNF) is considered a supplier and its claims are submitted to the appropriate carrier on the Form HCFA-1500. (See § 2255 and 3115.)

## 3101. AREA CARRIER - PHYSICIAN'S SERVICES

A. Physician Fee Schedule Services.--The jurisdiction for processing a request for payment for services paid under the Medicare Physician Fee Schedule (MPFS) is governed by the payment locality where the service is furnished. (See §15012.) When a physician or supplier furnishes physician fee schedule services in payment localities that span more than one carrier's service area, separate claims must be submitted to the appropriate area carrier 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 physician fee schedule claims for the payment locality where the out of office service was furnished has jurisdiction for that service as 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 services provided by physicians are within the same carrier jurisdiction that the physicians office(s) is/are located.

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 to insure correct claim processing jurisdiction and/or correct pricing of MPFS services. Ensure that multiple office situations are cross-referenced within your 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, return/reject the claim as unprocessable.

Physicians, suppliers and group practices who 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, sufficient information must be furnished on the claim concerning the specific location where the services were furnished so that you can determine the correct claims processing jurisdiction and apply the correct physician fee schedule amount.

In order to determine claims jurisdiction, Medicare approved charges, Medicare payment amounts, Medicare limiting charges and beneficiary liability, it is essential that Part B fee-for-service claims must include information concerning where the service was provided. (See Part 3, §4020.2 and Part 4, §2010 ff.)

If you receive 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 §3110ff. 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.

Carriers must accept claims that include place of service (POS) home, and/or a POS office, and /or a POS for a facility (other than home or office). If carriers receive a claim that includes more than one facility POS, (not home or office), they must continue to follow their current resolution process.

B. Misdirected HMO Claims.--Handle misdirected claims/services for HMO enrollees in accordance with §4267.1.

## 3110. DISPOSITION OF MISDIRECTED CLAIMS

This section applies to misdirected claims that are payable by local carriers and have been sent to the wrong carrier or are payable by the RRB, but have been sent to the local carrier. It does not apply to misdirected claims that are payable by a DMERC, but have mistakenly been sent to the incorrect DMERC. Current processes per the DMERC statement of work should be followed for those claims. It also does not apply to misdirected claims that are payable by a DMERC, but have mistakenly been sent to the local carrier or vice versa. DMERCs and carriers should continue with current claims processing procedures for these claims.

A. A Local Carrier Receives a Claim with Some or All Services that are in Another Local Carrier's Payment Jurisdiction.--When you receive a request for Medicare payment for services furnished outside of your payment jurisdiction, (see §3005.1), return assigned services as unprocessable, and deny unassigned services. Pay services correctly submitted to you.

Use the following messages:

Remittance Advice (RA)

Claim adjustment reason code 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.

New remark code N104 - This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov.

Medicare Summary Notice (MSN)

11.7 – This claim/service is not payable under our claims jurisdiction area. We have notified your provider that they must forward the claim/service to the correct carrier for processing.

Spanish - Esta reclamación/servicio no se paga bajo nuestra juridicción de reclamaciones. Le hemos notificado a su proveedor que debe enviar la reclamación/servicio a la agencia de seguros de Medicare Parte B apropiada para ser procesada.

B. A Local Carrier Receives a Claim for an RRB Beneficiary.--When you receive a request for Medicare payment from a provider for RRB beneficiaries, per §3005.1, return as unprocessable assigned services and deny unassigned services. Pay services correctly submitted to you.

Use the following messages:

RA

Claim adjustment reason code 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.

New remark code N105 - This is a misdirected claim/service for a RRB beneficiary. Submit paper claims to the RRB carrier: Palmetto GBA, P.O. Box 10066, Augusta, GA 30999. Call 866-749-4301 for RRB EDI information for electronic claims processing.

MSN

11.9 – This claim/service is not payable under our claims jurisdiction. We have notified your provider to send your claim for these services to the Railroad Retirement Board Medicare carrier.



Spanish - Esta reclamación/servicio no se paga bajo nuestra juridicción de reclamaciones. Le hemos notificado a su proveedor que debe enviar la reclamación por estos servicios a la Junta de Retiro Ferroviario (RRB, por sus siglas en inglés), agencia de seguros de Medicare Parte B.

C. Requested Action When RRB Receives a Claim that is not for an RRB Beneficiary.--CMS requests that when RRB receives a claim that is not for an RRB beneficiary that they return the claim to the sender and notify them that the claim must be submitted to the local carrier or DMERC for processing.

D. Misdirected HMO Claims.--Handle misdirected claims/services for HMO enrollees in accordance with §4267.1.

3110.1 Transfer of Claims Material Between Carrier and Intermediary.--If a beneficiary erroneously submits to you an HCFA-1490S with an itemized bill for services that must be paid by the Part A intermediary, forward such claims to the intermediary for the necessary action.

3110.2 Signature Requirements.--In the situation described in § 3110.1, intermediaries have been instructed to obtain hospital billings (including SSA-1554's) if necessary and that the patient's signature on the SSA-1490 satisfied the signature requirement for the hospital billings. Carrier will occasionally receive from hospitals SSA-1554's lacking a patient's signature but showing in the signature block an entry substantially as follows: "Patient's signature on SSA-1490 retained by Part A intermediary." The carrier is authorized to make payment on the basis of this entry.

## 3115. PAYMENTS UNDER PART B FOR SERVICES FURNISHED BY SUPPLIERS OF SERVICES TO PATIENTS OF A PROVIDER.

Payment for certain medical and other health services can be made either to the provider who arranges for the services or to the supplier of the services. (See § 2255.) For this purpose, a nonparticipating skilled nursing facility will be considered a supplier. If a participating provider or nonparticipating hospital arranges for these services, it should submit billings to the intermediary on the appropriate provider billing form (SSA-1483). If the supplier does not provide the services under arrangements with a provider, it can either accept an assignment and bill the carrier on an SSA-1490 or furnish the patient with an itemized bill.

Where a supplier regularly furnishes covered medical and other health services to inpatients of a provider or nonparticipating hospital, either the intermediary or the carrier should always be billed for such services so that billing does not vary on a case-by-case basis. The same billing arrangements should also continue to apply after a beneficiary exhausts his Part A benefits so that further benefits in that spell of illness are covered only under Part B.

The intermediary should ascertain whether the provider or supplier will bill for the services and notify the carrier of the billing arrangements. The carrier should confirm the supplier's understanding of the arrangements.

When a supplier furnishes these medical and other health services to patients of more than one institution, it need not make the same arrangements with all of them; that is, the supplier could arrange for one provider

to bill for all services furnished to its inpatients, and the supplier could bill directly all inpatients of another provider to whom it furnishes services.

Since payment can be made under Part A only for services furnished by a provider "under arrangements" with the supplier, i.e., the provider bills the program, suppliers and providers should be encouraged to arrange for the provider to bill the program.



Any billing submitted which is inconsistent with the agreed arrangements should be rejected, and the provider or supplier (or beneficiary) who billed the program should be advised that the claim must be refiled in the proper manner.

## 3116. PARENTERAL AND ENTERAL NUTRITION (PEN) CLAIMS JURISDICTION

There are two PEN specialty carriers. Each carrier's claims jurisdiction is determined by the PEN supplier's "Home Office" location. The western PEN carrier processes all PEN claims generated by suppliers with authorized PEN identification numbers that are located west of the Mississippi River and in Minnesota. The eastern PEN carrier processes all claims from PEN suppliers with authorized PEN identification numbers that are located each of the Mississippi River. (See §§3329 and 4450 for PEN claims processing instructions.)

Item 24f. The charge for each listed service.

Item 24g. The number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered.

Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., multiple ostomy or urinary supplies, medication dosages, or allergy testing procedures). When multiple services are provided, the actual number provided must be indicated.

For anesthesia, the provider must indicate the elapsed time (minutes) in item 24g. Convert hours into minutes and enter the total minutes required for this procedure.

Suppliers must furnish the units of oxygen contents except for concentrators and initial rental claims for gas and liquid oxygen systems. Rounding of oxygen contents is as follows:

- For stationary gas system rentals, suppliers must indicate oxygen contents in unit multiples of 50 cubic feet in item 24g, rounded to the nearest increment of 50. For example, if 73 cubic feet of oxygen were delivered during the rental month, the unit entry "01" indicating the nearest 50 cubic foot increment is entered in item 24g.

- For stationary liquid systems, units of contents must be specified in multiples of 10 pounds of liquid contents delivered, rounded to the nearest 10 pound increment. For example, if 63 pounds of liquid oxygen were delivered during the applicable rental month billed, the unit entry "06" is entered in item 24g.

- For units of portable contents only (i.e., no stationary gas or liquid system used), round to the nearest five feet or one liquid pound, respectively.

Item 24h. Leave blank. Not required by Medicare.

Item 24i. Leave blank. Not required by Medicare.

Item 24j. Leave blank. Not required by Medicare.

Items 24k. The PIN of the performing provider of service/supplier if they are a member of a group practice.

When several different providers of service or suppliers within a group are billing on the same Form HCFA-1500, show the individual PIN in the corresponding line item.

Item 25. The provider of service or supplier Federal Tax I.D. (Employer Identification Number) or Social

Security Number. The participating provider of service or supplier Federal Tax I.D. number is required for a mandated Medigap transfer.

Item 26. The patient's account number assigned by the provider of service's or supplier's accounting system. This field is optional to assist the provider in patient identification. As a service, any account numbers entered here will be returned to the provider.

Item 27. The appropriate block must be checked to indicate whether the provider of service or supplier accepts assignment of Medicare benefits. If MEDIGAP is indicated in block 9 and MEDIGAP payment authorization is given in item 13, the provider of service or supplier must also be a Medicare participating provider of service or supplier and must accept assignment of Medicare benefits for all covered charges for all patients.

The following providers of service/suppliers and claims can only be paid on an assignment basis:

- o Clinical diagnostic laboratory services;
- o Physician services to individuals dually entitled to Medicare and Medicaid;
- o Participating physician/supplier services,
- o Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, and clinical social workers;
- o Ambulatory surgical center services for covered ASC procedures; and
- o Home dialysis supplies and equipment paid under Method II.

Item 28. Total charges for the services (i.e., total of all charges in item 24f).

Item 29. Total amount the patient paid on the covered services only.

Item 30. Leave blank. Not required by Medicare.

Item 31. The signature of the practitioner or supplier, or his/her representative, and either the 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or alphanumeric date (e.g., January 1, 1998) the form was signed.

Item 32. The name, address, and zip code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office. Providers of service (namely physicians) must identify the supplier's name, address, zip code and PIN when billing for purchased diagnostic tests. When more than one supplier is used, a separate HCFA-1500 should be used to bill for each supplier.

For foreign claims, per §2312.2C, only the enrollee can file for Part B benefits rendered outside of the United States. These claims will not include a valid zip code. When a claim is received for these services on a beneficiary submitted HCFA-1490S, before the claim is entered in the system, it should be determined if it is a foreign claim. If it is a foreign claim, follow instructions in §2312ff for disposition of the claim. The carrier processing the foreign claim will have to make necessary accommodations to verify that the claim is not returned as unprocessable due to the lack of a zip code.

This item is completed whether the supplier personnel performs the work at the physician's office or at another location.

If a QB or QU modifier is billed, indicating the service was rendered in a Health Professional Shortage Area (HPSA), the physical location where the service was rendered must be entered if other than home.

If the supplier is a certified mammography screening center, the supplier must enter the 6-digit FDA approved certification number.

Item is completed for all laboratory work performed outside a physician's office. If an independent laboratory is billing, the place where the test was performed, and the UPIN must be indicated.

Item 33. The practitioner's/supplier's billing name, address, zip code, and telephone number. The PIN for the performing provider of service/supplier who is not a member of a group practice. Suppliers billing the DMERC will use the National Supplier Clearinghouse (NSC) number in this field.

The group PIN for the performing practitioner/supplier who is a member of a group practice.

F. Applicability of §1862(a)(7) of the Act to Preoperative Services.--

1. Preoperative Examinations.--For purposes of billing under the Physician Fee Schedule, medical preoperative examinations performed by, or at the request of, the attending surgeon does not fall within the statutory exclusion articulated in §1862(a)(7) of the Act. These examinations are payable if they are medically necessary (i.e., based on a determination of medical necessity under §1862(a)(1)(A) of the Act), and meet the documentation requirements of the service billed. Determination of the appropriate E/M code is based on the requirements of the specific type and level of visit or consultation the physician submits on his claim (e.g., established patient, new patient, consultation).

2. Preoperative Diagnostic Tests.--When billing under the Physician Fee Schedule, preoperative diagnostic tests performed by, or at the request of, the physician performing preoperative examinations, do not fall within the statutory exclusion articulated in §1862(a)(7) of the Act. These diagnostic tests are payable if they are medically necessary (i.e., they may be denied under §1862(a)(1)(A)).

G. ICD Coding Requirements for Preoperative Services.--All claims for preoperative medical examination and preoperative diagnostic tests (i.e., preoperative medical evaluations) must be accompanied by the appropriate ICD-9 code for preoperative examination (e.g., V72.81 through V72.84). Additionally, the appropriate ICD-9 code for the condition(s) that prompted surgery must also be documented on the claim. Other diagnoses and conditions affecting the patient should also be documented on the claim, if appropriate. The ICD-9 code that appears in the line item of a preoperative examination or diagnostic test must be the code for the appropriate preoperative examination (e.g., V72.81 through V72.84).

H. Medical Necessity Determination.--Medical necessity for specific preoperative services is determined by any applicable national coverage decisions. In the absence of a national coverage determination, medical necessity is determined by carrier discretion.

## 15048. PURCHASED DIAGNOSTIC TESTS

A. General.--Section 1842(n) of the Act establishes payment rules for diagnostic tests billed by a physician but performed by an outside supplier. For this purpose, diagnostic tests are tests covered under §1861(s)(3) of the Act other than clinical diagnostic laboratory tests. These include, but are not limited to, such tests as X-rays, EKGs, EEGs, cardiac monitoring, ultrasound, and the technical component of physician pathology services furnished on or after January 1, 1994. Physician pathology services are the services described in §§15022.B and C. (Note that screening mammography services are covered under another provision of the Act and are not subject to the purchased services limitation.) These rules apply to the test itself (the TC) and not to physicians' services associated with the test.

B. Payment.-- If a test is personally performed by a physician or is supervised by a physician, such physician may bill under the normal physician fee schedule rules. This includes situations in which the test is performed or supervised by another physician with whom the billing physician shares a practice. Section 2070 sets forth the various levels of physician supervision required for diagnostic tests. The supervision requirement for physician billing is not met when the test is administered by supplier personnel regardless of whether the test is performed at the physician's office or at another location.

If a physician bills for a diagnostic test performed by an outside supplier, the fee schedule amount for the purchased service equals the lower of the billing physician's fee schedule or the price he or she paid for the service. The lower figure is the fee schedule amount for purposes of the limiting charge. (See §17002.) The billing physician must identify the supplier (including the supplier's provider number) and the amount the supplier charged the billing physician (net of any discounts). A physician who accepts assignment is permitted to bill and collect from the beneficiary only the applicable deductible and coinsurance for the purchased test. A physician who does not accept assignment is permitted to bill and collect from the beneficiary only the fee schedule amount (as defined above) for the purchased test. The limiting charge provision is not applicable.

If the physician does not identify the supplier and provide the other required information, no payment is allowed, and the physician may not bill the beneficiary any amount for the test.

C. Sanctions.--Physicians who knowingly and willfully, in repeated cases, bill Medicare beneficiaries amounts beyond those outlined in §15048.B are subject to the penalties contained under §1842(j)(2) of the Act.

D. Questionable Business Arrangements.--Section 15048.B imposes no special charge or payment constraints on tests performed by a physician or a technician under the physician's supervision. There are two requirements for all diagnostic tests under §1861(s)(3) of the Act, as implemented by 42 CFR §410.32 and §§15021 and 2070. Namely, the test must be ordered by the treating practitioner, and the test must be supervised by a physician. However, attempts may be made by the medical diagnostic community to adjust or establish arrangements which continue to allow physicians to profit from other's work or by creating the appearance that the physician has performed or supervised his/her technicians who are employed, contracted, or leased. Some of these arrangements may involve cardiac scanning services and mobile ultrasound companies leasing their equipment to physicians for the day the equipment is used, and hiring out their staff to the physicians to meet the supervision requirement.

The bonafides of such arrangements may be suspect and could be an attempt to circumvent the prohibition against the mark-up on purchased diagnostic tests. If you have any doubt that a particular arrangement is a valid relationship where the physician is performing or supervising the services, this should be investigated. The Office of the Inspector General (OIG) has responsibility for investigating violations of §1842(n) of the Act.

Another arrangement to circumvent the purchased diagnostic service provision is for the ordering physician to reassign his/her payment for the interpretation of the test to the supplier. The supplier, in turn, bills for both the test and the interpretation and pays the ordering physician a fee for the interpretation. This arrangement violates §1842(b)(6) of the Act, which prohibits Medicare from paying benefits due the person that furnished the service to any other person, subject to limited exceptions discussed in §3060.D. Also, this arrangement could constitute a violation of §1128 B (b) of the Act, which prohibits remuneration for referrals (i.e., kickbacks).

Violations of §1128B (b) of the Act may subject the physician or supplier to criminal penalties or exclusion from the Medicare and Medicaid programs. Illegal remuneration for referrals can be found even when the ordering physician performs some service for the remuneration.