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## Purchased Diagnostic Testing Script

Welcome to the Wisconsin Physicians Service (WPS) Medicare Part B presentation on Purchased Diagnostic Testing. This program provides information on when, where and how submitting claims for a test someone else performed is appropriate. This program along with an article we have written provides the information on the correct submission of claims.

We put together an article containing more detailed information than what we can provide in this Power Point. This article includes specific billing instructions. You can access this article on the Website you see on the slide.

Medicare reimburses the performing provider for services he/she performs. An exception to this rule is Purchased Diagnostic services. When we talk about purchased services, we are talking about services having both a professional and a technical component. These could be x-rays, Cardio tests, and surgical pathology in addition to others. Clinical lab services could also fall under this guideline.

This exception does not apply to non-physician practitioners. He/she simply bills the service he/she performed and the other entity does the same.

Our article has detailed information on claim submission. The article shows the required information and required fields on the 1500 form and the segments of an electronic claim. The different types of purchased services may have different requirements. One requirement true for all services is the zip code. The claim must indicate the zip code of where physician or supplier performed each portion of a test. This allows Medicare to make correct payment.

Paper claims must contain only one component of a purchased test. Electronic claims can contain both when the claim contains the required information on the line level.

The billing provider must ensure the provider performing the services is a Medicare enrollee. This does not mean they must have enrollment in the same jurisdiction or with the same carrier as the billing provider. The billing provider has the responsibility to verify Medicare has no sanctions against the performing provider. So what do you do if the performing provider does not have Medicare enrollment and either will not or cannot enroll? You cannot bill for the services.

See the Website listed on the slide to determine sanctioned providers.

The billing provider needs to be aware of questionable situations. These are situations where the provider is receiving additional payment or benefits for ordering or referring services. Any arrangement allowing someone to profit from someone else's work is questionable. Medicare is instituting rules on provider self-referrals. We will not discuss these rules and situations during this presentation. You want to speak with your attorney or investigate the information yourself to determine whether this may be a problem for you.

With the advent of all of the new technology, it is possible for a provider to bill for services rendered in another part of the country. There have been items in the news about providers even in other countries providing the interpretation and report for radiology and cardiology procedures. Medicare does not pay for services provided outside the United States.



We have instruction in an article on our Website discussing the billing requirements for both electronic and paper claims. Providers must submit claims electronically unless they meet one of the exceptions as part of the Administrative Simplification Compliance Act or (ASCA). If your software is not allowing you to submit these claims correctly, you need to update your software.

There are three situations where a provider may bill for services he/she did not render.

1. The physician purchases a technical component from an outside supplier
2. The physician or other supplier purchases the professional component – interpretation and report from a physician
3. An independent clinical laboratory purchases the services of a reference laboratory for clinical specimens.

You want to verify the situation you have in order to bill correctly. This results in accurate and timely claim payment and reduces the number of telephone calls and requests for redeterminations required by your office.

A physician office arranges for another supplier to provide the technical component of a service. The patient goes to the other supplier, has the service and then the physician provides the professional component. If the physician is not performing the professional component, then they cannot bill for a purchased service.

Medicare is aware of questionable situations where the supplier is performing the technical portion and provides the written interpretation and report for the physician to sign and date. This is not a professional service. In this situation, the supplier submits the charges to Medicare, not the physician.

Medicare is aware of some suspect situations – a supplier brings the equipment to the physician's office and leases the equipment and the technicians to the physician for the day. The physician cannot bill a global service and must bill as purchased or bill only the professional component.

A hospital is not an outside supplier for their patients. The hospital can be a supplier for the technical component when providing services to non-hospital patients. The difference in determining whether the patients are inpatients or outpatients is whether the hospital is billing charges to Part A. If not, then the patient is a non-patient. If so, then the patient is a hospital patient.

Medicare can allow an independent lab to provide the technical portion of anatomical pathology to hospital patients and bill directly for the service. There are many requirements for this situation. The first is there has to have been a valid agreement in place prior to July 22, 1999. You can find more information on this issue in the CMS IOM 100-04, Chapter 12, Section 60.

The purchased diagnostic instructions do not apply to non-physician practitioners. The NPP only bills for the service he/she performed.

Claims for purchased technical components require certain information. The claim must show:

- All claims for technical components must include an indicator to show whether the billing provider purchased the service.
- The claim for purchased technical services must have the amount paid for the service. The purchased technical component of a mammography does not require this information.



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- The claim must show the location of where the provider performed the service by use of the zip code.

Electronic claims can have multiple services when submitting information on the line rather than the claim level. Paper claims must submit each portion of the service and each test on separate claims.

Medicare's allowed amount for the service is the lower of the fee schedule amount for the location of where the provider performed the services, the physician billed amount, or the amount the physician paid for the service.

For providers not accepting assignment, the limiting charge is the lower amount as described.

This limitation does not apply to an independent lab.

If Medicare does not receive the information correctly, we deny the claim as unprocessable and the physician cannot collect from the patient until Medicare receives the correct information.

Here are some examples of this situation

Dr. Jones contracts with ABC Medical Clinic to provide the technical component of radiology services. Dr. Jones provides the written interpretation and report for the service. ABC Medicare clinic does not bill Medicare but instead bills Dr. Jones. Dr. Jones bills the professional and technical services to Medicare separately. For the technical component, he indicates he purchased the service and provides the amount charged by ABC Medical Clinic. Dr. Jones also shows the address and zip code of where ABC Medical Clinic performed the charge.

Medicare then allows or denies the service based on our normal rules and the allowed amount is the lower of the billed amount, the fee schedule, or the amount charged by ABC Medical Clinic.

If ABC Medical Clinic leases the equipment to Dr. Jones for the day, Dr. Jones must still bill as purchased. If ABC Medical Clinic provides an interpretation and report for Dr. Jones to sign and date, then ABC Medical provided the entire service and should submit global charges to Medicare.

Medicare does not reimburse for a purchased interpretation if the physician ordering the service is the same physician as is providing the purchased interpretation. The physician initiating the test is independent of both the supplier providing the service and the physician providing the interpretation. The person providing the interpretation does not see the patient.

Keep in mind what we talked about before. Medicare does not pay for services provided outside the United States.

An IDTF may also bill for purchased interpretation. The IDTF, when enrolling with Medicare, must identify they will purchase interpretations and submit those charges, and must identify the physicians that will perform the interpretations. This information goes on the 855 B in Attachment 2, Section C. An IDTF must keep this information current.

If the physician assigns benefits to an IDTF, this is not a purchased service and the IDTF bills a global service.



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Please see the article on our Website for the complete billing instructions.

<http://www.wpsmedicare.com>, choose Part B or J5 MAC as appropriate, choose education from the banner, and choose specialty specific and then Purchased Diagnostic Tests.

The supplier is not required to provide the indicator as to whether they purchased the professional component. Medicare does not require the supplier to provide the physician billed amount. Always keep in mind those questionable situations we discussed before.

Entities submitting a claim for the purchased professional component of an anatomical pathology service may need to submit the purchase price. Please see the information contained on the Website listed on the slide. We are currently waiting on billing instructions for these services. You may wish to discuss this with your attorney.

A Critical Access Hospital may not bill for purchased interpretations. The CAH does not bill Medicare Part B for the technical component and that is one of the requirements. The performing physician can either reassign benefits to the CAH or simply bill the procedure on their own.

#### Examples

XYZ Radiology Company provides the technical component of a diagnostic test. They send the technical portion (either physically or electronically) to Dr. Reader to provide the written interpretation and report of the service. If Dr. Reader did not order the test for the patient and Dr. Reader is within the United States, then XYZ Radiology may bill Medicare for the purchased professional component. This same situation applies to anatomical pathology.

The billing provider must be a specialty 69 for independent clinical laboratory (ICL). The ICL submits the claims for these services to the contractor for their jurisdiction. They record the zip code of where the reference lab performed services so the contractor can make correct payment. The correct Place of Service (POS) code is 81.

This information does not apply to a physician's office. We have further information on this type of situation in a later slide.

The billing provider is not required to get a Provider Transaction Access Number (PTAN) for the contractor with jurisdiction over the reference laboratory nor is the reference laboratory required to get a PTAN for the billing provider's jurisdiction. Keep in mind both providers must have Medicare enrollment.

There are requirements for an ICL billing for services performed by a reference laboratory. The referring/billing lab must be part of a rural hospital OR the referring lab owns the reference lab OR the reference lab owns the referring lab OR another entity owns both the Reference lab and the referring lab OR the referring lab does not exceed the 30% threshold.

The use of Modifier 90 simply tells us a reference lab and not the billing provider performed the services.

Do not submit charges for both referred and non-referred services on the same claim. The information requirements are different. The claim information must contain the Clinical Laboratory Improvement Amendment (CLIA) numbers for both laboratories when billing for services sent to a reference lab.



Clinical Lab services are not subject to the payment limitation as we've discussed before. Medicare pays clinical lab services based on the lower of the billed amount, the local fee schedule amount, or the national fee schedule amount. The claim must show the zip code of where the reference lab physically performed the service.

Don't use the 90 modifier when billing a Not Otherwise classified code. Medicare doesn't recognize the 90 modifier with this code. Simply bill the NOC code and let us know in the narrative field you have additional documentation. We then ask you for documentation. You'll send us the description of the service you provided along with the modifier and the information on the reference lab.

The article on our Website provides information on finding the Medicare Fee Schedule Relative Value File to determine whether a code is part of the clinical lab fee schedule. A clinical lab service has an "x" in the Status Field. If your code has an "X," you can then look at the Clinical lab fee schedule to determine if there are fees available.

#### Example

The physician sends the specimen to ABC Laboratory to perform clinical laboratory services. ABC Laboratory performs some of the services and sends the remainder on to Bigger Laboratory for completion of the rest. ABC Laboratory must bill the tests they performed on a separate claim from the ones they sent to Bigger Laboratory. The claim for the referred tests must include the 90 Modifier, the CLIA, and NPI for both labs.

#### Example

The physician sends the specimen to ABC laboratory to perform clinical laboratory services. ABC sends the specimen to Bigger laboratory to perform all the tests. ABC lab bills for all the services using the 90 modifier. The claim again must include the CLIA and NPI for both.

The physician sends the specimen to ABC laboratory who then send the specimen to Bigger laboratory who then sends the specimen to Giant Laboratory. When ABC bills for these services, they must submit the information for Giant Laboratory.

There are two situations where purchased rules do not apply. One is a physician sending clinical lab specimens to an outside laboratory. The other is a hospital billing for technical services for their inpatients.

Medicare receives numerous phone calls from the lab asking about a duplicate denial. When Medicare does the research, we find the physician submitted the claim for the lab even though they did not perform the service. Medicare knows for outside payers, a physician may be able to bill for the lab test, but not for Medicare.

In this situation, only the lab may bill Medicare. Medicare, the lab, and physician office involved spend a lot of time researching these duplicate denials. When we request documentation to show who rendered the service, the physician office sends documentation showing the clinical lab.

Physician offices cannot bill for clinical lab services sent to an outside laboratory for their Medicare patients.



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For Hospital patients, (these are patients where the hospital is billing charges to Medicare Part B), the hospital cannot purchase and bill separately for the technical component of a diagnostic test. The hospital includes these charges in the claim to Medicare part A. The supplier looks to the hospital for payment of the services, not Medicare Part B.

A physician providing professional services bills Medicare Part B directly.

See the previous exceptions discussed for hospitals and anatomical pathology.

Our next slide provides the resources we've used to put together this material. Slide 23 shows several sections of the Internet Only Manual.

You can access this manual on the Centers for Medicare & Medicaid Services Website

<http://www.cms.hhs.gov/manuals>

Choose Internet Only Manuals and then the manual reference.

Here are additional references for your use in verifying the correct billing of purchased services.

This slide also includes a change request showing changes made to the instructions not yet included in the manuals listed above. You can access the Change Request (CR) on the following Website

<http://www.cms.hhs.gov/MLNMArticles>

Choose the year CMS issued the CR and then perform a search for the number.

Thank you for your time.