CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1873	**Date: December 11, 2009**
	Change Request 6375

Transmittal 1823 is rescinded and replaced by Transmittal 1873. The implementation date for Business Requirement 6375.10 and section 10.6.3 only of the manual instruction has been changed to July 1, 2010. All other information remains the same.

SUBJECT: Place of Service (POS) and Date of Service (DOS) Instructions for the Interpretation (Professional Component) and Technical Component of Diagnostic Tests

I. SUMMARY OF CHANGES: This Change Request reminds contractors of the correct place of service (POS) codes and informs contractors of the correct POS for the interpretation (professional component) and technical component of diagnostic tests. It also informs contractors of the date of service (DOS) for the interpretation of diagnostic tests

New / Revised Material
Effective Date: January 4, 2010
Implementation Date: January 4, 2010 and July 1, 2010 for Business Requirement 6375.10 and section 10.6.3 only of the manual instruction.

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. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	26/Table of Contents
R	26/10.6/Carrier Instructions for Place of Service (POS) Codes
N	26/10.6/10.6.1/Place of Service Instructions for the Interpretation of Diagnostic Tests
N	26/10.6/10.6.2/Place of Service Instructions for the Technical Component (TC) and Professional Component (PC or Interpretation) of Diagnostic Tests Not Personally Performed Or Supervised By A Physician

N	26/10.6.3/Date of Service (DOS) Instructions for the Interpretation and Technical Component of Diagnostic Tests

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1873	Date: December 11, 2009	Change Request: 6375

Transmittal 1823 is rescinded and replaced by Transmittal 1873. The implementation date for Business Requirement 6375.10 and section 10.6.3 only of the manual instruction has been changed to July 1, 2010. All other information remains the same.

SUBJECT: Place of Service (POS) and Date of Service (DOS) Instructions for the Interpretation (Professional Component) and Technical Component of Diagnostic Tests

Effective Date: **January 4, 2010**

Implementation Date: January 4, 2010 and July 1, 2010 for Business Requirement 6375.10 and section 10.6.3 only of the manual instruction.

I. GENERAL INFORMATION

A. Background: Instructions are provided regarding the place of service (POS) and the date of service (DOS) for the interpretation or professional component and the technical component of diagnostic tests. In the CY 2009 physician fee schedule (PFS) final rule (73 FR 69799, November 19, 2008), CMS finalized changes to 42 C.F.R. §414.50 and renamed it, "**Physician or other supplier billing for diagnostic tests performed or interpreted by a physician who does not share a practice with the billing physician or other supplier**." This regulation previously required an anti-markup payment limitation to the technical component (TC) of a diagnostic test when a physician billed for the TC of a diagnostic test that was performed by another physician who did not share a practice with the billing physician. As of January 1, 2009, the application of the anti-markup payment limitation, besides applying to the TC of a diagnostic test in certain situations, may also apply to the professional component (PC), or test interpretation, of a diagnostic test in certain situations. Because of these changes to what was formerly referred to as a "purchased diagnostic test," CMS will be changing all references of the term "purchased diagnostic test and purchased test interpretation in the Internet-Only Manual (IOM) to "anti-markup test." These changes will be made in the future to Pub. 100-04, chapter 1, sections 30.2.9 and 30.2.9.1, as well as to Pub. 100-04, chapter 13, section 20.2.4 and other IOM sections that make reference to the term "purchased diagnostic test or purchased test interpretation."

B. Policy: Contractors are informed of the correct POS and the DOS for the interpretation (professional component) and technical component of diagnostic tests.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6375.1	Contractors shall be aware of the instructions in Pub. 100-04, Medicare Claims Processing Manual, chapter 26, sections 10.6-10.6.3.	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6375.2	Contractors shall educate providers and suppliers about the use of POS code 11 (office) or POS code 99 (other) as the POS for an interpretation performed in a physician's home. Where the appropriate POS code may be unclear, the contractor can provide guidance regarding which code to use.	X			X						
6375.3	If an interpretation is performed in a hotel room, contractors shall educate providers and suppliers about the use of POS code 11 (office), POS code 16 (temporary lodging), or POS code 99 (other) as the POS. Where the appropriate POS code may be unclear the contractor can provide guidance regarding which code to use.	X			X						
6375.4	Contractors shall educate providers and suppliers about the POS code for the place where a teleradiology interpretation is read. In cases where it is unclear which POS code applies, the contractor can provide guidance**.**	X			X						
6375.5	Contractors generally shall not make payment for health care or supplies provided outside the United States. Exceptions to the outside the United States exclusion are cited in Pub. 100-04, chapter 26, section 10.6.1. Also see Pub. 100-02, Medicare Benefit Policy Manual, chapter 16, section 60 for a clarification of the subcontracting of services to another provider or supplier located outside the United States.	X			X						
6375.6	Contractors shall educate providers and suppliers about the POS code where the service takes place for an interpretation performed in an office suite that is neither the test location nor the physician's office. The POS code may be POS code 11 (office) or POS code 99 (other). The contractor can provide guidance regarding which POS code applies.	X			X						
6375.7	Contractors shall educate providers and suppliers about the POS code for the place where the service takes place, where an interpretation is provided under arrangement to a hospital and there is a separate technical component and professional component. In cases where it is unclear which POS code applies, the contractor can provide guidance.	X			X						
6375.8	There is no POS code for an interpretation that is provided under arrangement to a hospital and the test and interpretation are not separately billable (global billing).	X			X						
6375.9	Contractors shall educate providers and suppliers about the use of the POS code where the service takes place for an interpretation that is not performed under SNF consolidated billing. The contractor can provide guidance	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	regarding which codes applies where the appropriate POS code may be unclear.										
6375.10	On July 1, 2010, contractors shall educate providers and suppliers about the use of the actual calendar date that the interpretation was performed as the date of service (DOS) for the interpretation. Note: Special rules apply for the DOS of the technical component of clinical laboratory and pathology specimens and are contained in 42 CFR 414.510.	X			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6375.11	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X			X						

IV. SUPPORTING INFORMATION

Section A: for any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Roberta Epps, Roberta.Epps@cms.hhs.gov

Post-Implementation Contact(s): Regional Offices

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs)*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs),* include the following statement:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual
Chapter 26 - Completing and Processing Form CMS-1500 Data Set

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(Rev. 1873, 12-11-09)

10.6 - Carrier Instructions for Place of Service (POS) Codes

(Rev. 1873, Issued: 12-11-09, Effective: 01-04-10, Implementation: 01-04-10)

If the physician bills for lab services performed in his/her office, the code for "Office" is shown. If the physician bills for a lab test furnished by another physician, who maintains a lab in his/her office, the code for "Other" is shown. If the physician bills for a lab service furnished by an independent lab, the code for "Independent Laboratory" is used. Items 21 and 22 on the Form CMS-1500 must be completed for all laboratory work performed outside a physician's office. If an independent lab bills, the place where the sample was taken is shown. An independent laboratory taking a sample in its laboratory shows "81" as place of service. If an independent laboratory bills for a test on a sample drawn on a hospital inpatient, it uses the code for "Hospital Inpatient".

For hospital visits by physicians, presume, in the absence of evidence to the contrary, that visits billed for were made. However, review a sample of physician's records when there are questionable patterns of utilization. Confirm these visits where the medical facts do not support the frequency of the physician's visits or in cases of beneficiary complaints. If questioning whether the visit had been made, ascertain whether the physician's own entry is in the patient's record at the provider. Accept an entry where the nurses' notes indicate that the physician saw the patient on a given day. A statement by the beneficiary is also acceptable documentation if it was made close to the alleged date of the visit. Entries in the physician's records represent possible secondary evidence. However, these are of less value since they are self-serving statements. Exercise judgment regarding their authenticity. The policy requiring daily physician visits is not conclusive if, in the individual case, the facts did not support a finding that daily visits were made.

If a claim lacks a valid place of service (POS) code in item 24b, or contains an invalid POS in item 24b, return the claim as unprocessable to the provider or supplier, using RA remark code M77. Effective for claims received on or after April 1, 2004, *only* one POS (other than Home – 12) *may be submitted* on Form CMS-1500 for services paid under the MPFS and anesthesia services. If the place of service is missing and the carrier cannot infer the place of service from the procedure code billed (e.g., a procedure code for which the definition is not site specific or which can be performed in more than one setting), then return assigned services as unprocessable and develop for the place of service on nonassigned claims.

If place of service is inconsistent with procedure code billed, then edit for consistency or compatibility between the place of service and site-specific procedure codes. If the place of service is valid but inconsistent or incompatible with the procedure billed (e.g., the place of service is inpatient hospital and the procedure code billed is office visit), then return assigned services as unprocessable and develop nonassigned services since the carrier typically will not know whether the procedure code or the place of service is incorrect in such instances. *Edit for the validity of the place of service coding.* If the place of service code is *not valid* (e.g., the number designation has not been assigned or defined by CMS), then return assigned services as unprocessable and develop for a valid place of service on nonassigned line items.

NOTE: *The POS codes designate the actual place where the service was provided. It is, therefore, important that providers bill the correct POS code. The use of office or POS code 11 in certain situations has been problematic. Physicians who perform services in an ambulatory surgical center (ASC) shall use POS code 24. Physicians are not to use office (POS code 11) for ASC based services unless the physician has an office at the same physical location of the ASC and the physician service was actually performed in the office suite portion of the facility. However, no concurrent or overlapping hours can exist between the ASC and the physician's office. Physicians who perform services in a hospital outpatient department shall use POS code 22 unless the physician maintains separate office space in the hospital or on hospital property and that physician office space is not considered a provider-based department of the hospital as defined in 42. C.F.R. 413.65. Physicians shall use POS code 11 (office) where a physician maintains separate office space in the hospital or on hospital property and that physician office space is not considered a provider-based department of the hospital as defined in 42. C.F.R. 413.65. and the service was actually performed in the office suite portion of the department. Use of POS code 11 or office in the hospital outpatient department or on hospital property is subject to the physician self-referral provisions set forth in 42 C.F.R 411.353 through 411.357. The Medicare contractor can provide guidance regarding which code applies in cases where the appropriate POS code may be unclear.*

10.6.1 - Place of Service Instructions for the Interpretation of Diagnostic Tests

(Rev. 1873, Issued: 12-11-09, Effective: 01-04-10, Implementation: 01-04-10)

A. Interpretation Performed In Physician's Home

The appropriate POS code reflects the actual place where the service was provided. If the interpretation of an image takes place in a physician's home, the POS would be either office (POS 11) if it meets the definition of office or "other" (99). The practice locations reflected in the physician's enrollment information may be instrumental in making the POS determination in this situation. The Medicare contractor can provide guidance regarding which code applies in cases where the appropriate POS code may be unclear.

For physician fee schedule (PFS) payment purposes the determinant of payment is the locality where the service is performed. Medicare has both facility and non-facility designations for services paid under the physician fee schedule. In accordance with Chapter 1, Section 10.1.1 (Payment Jurisdiction Among Local Carriers for Services Paid Under the Physician Fee Schedule and Anesthesia Services) of this manual, the jurisdiction for processing a request for payment for services paid under the PFS is governed by the payment locality where the service is furnished and will be based on the ZIP Code. CMS requires that the ZIP Code of the interpreting physician's location be placed on the claim form in order to determine the appropriate locality.

B. Interpretation Performed in a Hotel Room

If the interpretation of an image takes place in a hotel room, the POS would be office (POS 11) only if the hotel room is considered as the physician's office (e.g., it meets the definition of office and is shown as an "office" practice location in the physician's enrollment information). If both the physician and the patient are located in the hotel room at the time that the interpretation is performed, the POS code would most likely be the POS code for temporary lodging (POS 16). If the hotel room is neither the office of the physician nor the temporary lodging of the patient then the appropriate POS is "other" (POS 99). However, as stated above, the Medicare contractor ***can*** *provide guidance regarding which code applies in cases where the appropriate POS code may be unclear.*

C. Interpretation Provided Telephonically by Wireless Remote

Teleradiology services (radiology services that do not require a face-to-face encounter with the patient furnished through the use of a telecommunications system) are discussed in Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 30. The interpretation of an x-ray, electrocardiogram, electroencephalogram and tissue samples are listed as examples of these services.

The POS code for a teleradiology interpretation is generally the place where the interpretation is read. The ZIP Code for the POS shall be based on the setting/location where the interpretation takes place. In cases where it is unclear which POS code applies, the Medicare contractor can provide guidance.

D. Interpretation Provided Outside of the United States

Generally, Medicare will not pay for health care or supplies that are performed outside the United States (U.S.). The term "outside the U.S." means any where other than the 50 states of the U.S., the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. See Pub. 100-02, chapter 16, section 60, for exceptions to the "outside the U.S." exclusions.

E. Interpretation Performed In an Office Suite That Is Neither The Test Location Nor The Physician's Office

The appropriate POS code is the place where the service takes place. If the interpretation is performed in a location other than the main location of the physician group, and the location meets the definition of office, the POS code is office (11). If the physician performs the interpretation from home, the POS code is either office (11) if it meets the definition of office or other (99). In cases where it is unclear which POS code applies, the Medicare contractor can provide guidance.

F. Interpretation Provided Under Arrangement-To A Hospital

Separate Technical Component (TC) and Professional Component (PC)

If a diagnostic test which has a separate technical component (TC) and professional component (PC) is provided under arrangement to a hospital, the physician who reads the test can bill and be paid for the professional component. Both the technical and professional components of the test are also subject to the physician self-referral prohibition.

The appropriate POS code is the place where the service takes place. If the interpretation is performed in the hospital setting, the POS code is hospital outpatient (22). If the interpretation is performed at a location other than the location of the physician's office and the location meets the definition of office, the POS code is office (11). If the physician performs the interpretation from home, the POS code is either office (11) if it meets the definition of office or other (99). In cases where it is unclear which POS code applies, the Medicare contractor can provide guidance.

Global Service

When a physician performs a diagnostic test under arrangement to a hospital and the test and the interpretation are not separately billable, the interpretation cannot be billed by the physician. The hospital is the only entity that can bill for the diagnostic test which encompasses the interpretation. There is no POS code for the interpretation. The POS code for the test including the interpretation is hospital outpatient (22).

G. Interpretation Not Performed Under SNF Consolidated Billing

One of the service categories that the law excludes from the SNF Consolidated Billing provision is physician services, which are separately billable to the Medicare Part B contractor. The physician service for the interpretation is billed directly to the Medicare Part B contractor.

Since many diagnostic tests include both a technical component and a professional component, suppliers need to generate two bills. For example, with regard to diagnostic radiology services, such as x-rays, the physician service exclusion applies only to the professional component of the diagnostic radiology service (representing the physician's interpretation of the diagnostic test).

The appropriate POS code is the place where the service takes place. The Medicare contractor can provide guidance regarding which code applies in cases where the appropriate POS code may be unclear.

10.6.2 - Place of Service Instructions for the Technical Component (TC) and Professional Component (PC or Interpretation) of Diagnostic Tests Not Personally Performed Or Supervised By A Physician

(Rev. 1873, Issued: 12-11-09, Effective: 01-04-10, Implementation: 01-04-10)

The appropriate POS code should be identified as well as the ZIP Code.

The billing requirements applicable to diagnostic services that are not personally performed by a physician or other supplier are described in 42 C.F.R 414.50. This is commonly referred to as the anti-markup payment limitation. In order to avoid application of the anti-markup payment limitation, the physician performing the test must share a practice with the billing physician or other supplier. There are two ways a performing physician may share a practice with the billing physician or other supplier:

(i) If the performing physician furnishes substantially all (for purposes of this section, at least 75 percent) of his or her professional services through the billing physician or other supplier; or

(ii) If the technical component (TC) or professional component (PC) of the diagnostic test is performed in the office of the billing physician or other supplier. The office of the billing physician or other supplier is any medical office space (regardless of the number of locations) in which the ordering physician or other supplier regularly furnishes patient care, and includes space where diagnostic testing is furnished, if the space is located in the same building (as defined in 42 C.F.R. 411.351, of the physician self-referral rules).

10.6.3 - Date of Service (DOS) Instructions for the Interpretation and Technical Component of Diagnostic Tests

(Rev. 1873, Issued: 12-11-09, Effective: 01-04-10, Implementation: 07-01-10)

The appropriate DOS for the professional component is the actual calendar date that the interpretation was performed. For example, if the test or technical component was performed on April 30th and the interpretation was read on May 2nd, the actual calendar date or DOS for the performance of the test is April 30th and the actual calendar date or DOS for the interpretation or read of the test is May 2nd.

***NOTE**: Special rules apply for the DOS of the technical component of clinical laboratory and pathology specimens and are contained in 42 CFR 414.510.*