Codify
BY AAPC

Part B Insider (Multispecialty) Coding Alert

Physician Notes: Purchasing Tests Outside Your Carrier's Region Won't Be A Problem Soon

But be careful to avoid excluded providers

You'll be able to bill your local carrier for purchased diagnostic tests or interpretations, even if they were performed in another carrier's area, starting next April.

Since last April, the **Centers for Medicare & Medicaid Services** has required suppliers to bill for diagnostic tests or their interpretation based on the location where the tests were performed. This requirement has caused problems for some providers, because of enrollment restrictions, when they've been unable to receive reimbursement for tests or interpretations they purchased from a provider located outside their local carrier's jurisdiction.

But in Change Request 3481, issued Oct. 29, CMS tells the carriers to accept claims for purchased diagnostic tests or interpretations, "regardless of where the service was furnished." This change will take effect with the April 2005 implementation of a national abstract file containing HCPCS codes for every purchased test or interpretation billable in each locality around the country.

The physician who bills will be responsible for ensuring the provider who performed the purchased test or interpretation was in good standing and not excluded from Medicare.

Separately, CMS instructs the carriers to move over to average sales price plus six percent for Medicare physician drugs, except for blood products, infusion drugs, vaccines and some other drugs. In Change Request 3539, CMS spells out the process for implementing the new drug rates. This process appears to have caused some problems for the carriers, whose systems can only accept two digits after a decimal point instead of the three digits the ASP file contains. In a separate transmittal (Change Request 3436) CMS warns the carriers to alter their systems to accommodate this format.

Another recent transmittal instructs the Durable Medical Equipment Regional Carriers to use the Medicare Modernization Act database to price the drug Trepostinil (Q4077), resulting in an allowance of $61.75 per dose (Change Request 3533). And CMS also tells all carriers to put in place edits to detect duplicate claims that are in process at the same time (Change Request 3347).

Even though drug spending has gone up sharply, it's not the main reason for the steep increase in Medicare physician spending, commissioners told the Oct. 28 meeting of the **Medicare Payment Advisory Commission**. Physician services have accounted for 82 percent of the total rise in physician-associated spending, which includes drugs and lab services. Commissioners blamed growth in "volume and intensity" of spending, plus overuse of imaging services and diagnostic tests.