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# Update to Medicare Claims Processing Manual, Chapters 1, 23 and 35

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Related Change Request (CR) Number: 10882
Related CR Release Date: December 6, 2019
Effective Date: March 9, 2020
Related CR Transmittal Number: R4473CP
Implementation Date: March 9, 2020

## PROVIDER TYPES AFFECTED

This MLN Matters Article is intended for physicians, providers and suppliers billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

## WHAT YOU NEED TO KNOW

Change Request (CR) 10882 revises the "Medicare Claims Processing Manual" Chapters 1 and 35, to add new sections on global billing and separate Technical Component and Professional Component (TC/PC) billing instructions. Make sure your billing staffs are aware of these changes.

## BACKGROUND

CR 10882 revises the "Medicare Claims Processing Manual", Chapters 1 and 35, to add new sections on Global Billing and Separate TC/PC billing instructions. For both paper and electronic claims, when a global diagnostic service code is billed (for example, no modifier TC and no modifier -26), the address where the TC was performed must be reported on the claim. Global billing does not apply to anti-markup tests.

## CR10882 Key points

### Global Billing

Global billing is acceptable when both the TC and PC are performed by the same entity and both the TC and the PC are furnished within the same MPFS payment locality. The TC and PC may be furnished in different locations as long as they are furnished within the same MPFS, payment locality.

If the global diagnostic test code is billed, providers should report the name, address and National Provider Identifier (NPI) of the location where the TC was furnished in Items 32 and 32a (or the 837P electronic claim equivalent). See the "Medicare Claims Processing Manual", Chapter 1, Sections 80.3.2.1.2 and 80.3.2.1.3 for more information regarding what is required in Items 32 and 32a.



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### Separate TC/PC Billing

When the TC and PC are billed separately (not billed globally), providers should report the name, address and NPI of the location where each component was performed. If the billing provider has an enrolled practice location at the address where the service was performed, the billing provider/supplier may report their own name, address and NPI in Items 32 and 32a (or the 837P electronic claim equivalent).

If the PC was performed at an unusual or infrequently used location, the location of the provider's or supplier's closest Medicare-enrolled practice location may be used in Item 32.

The NPI in Item 32a must correspond to the entity identified in Item 32 (no matter if it is the group, hospital, the Independent Diagnostic Testing Facility, or the individual physician. The only exception for Medicare claims is when a service is performed out of jurisdiction and is subject to the anti-markup or a reference lab service. See "Medicare Claims Processing Manual", Chapter 1,Section 30.2.9 and Chapter 16, Section 40.1 for instructions specific to anti-markup and reference lab, respectively.

## ADDITIONAL INFORMATION

The official instruction, CR10882, issued to your MAC regarding this change, is available at https://www.cms.gov/files/document/r4473cp.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list

## DOCUMENT HISTORY

| Date of Change | Description |
|---|---|
| December 9, 2019 | Initial article released. |