



Provider Inquiry Assistance

Claims Processing Instructions for Diagnostic Tests Subject to the Anti-Markup Pricing Limitation – JA6371

Note: MLN Matters® article MM6371 was revised to add a reference to a related MLN Matters® article MM6627, regarding more current information on the Medicare manual revisions that address the removal of references to “purchased tests.” That article is available at <http://www.cms.gov/MLN MattersArticles/downloads/MM6627.pdf> on the CMS website.

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Key Words

MM6371, CR6371, R445OTN, Diagnostic, Tests, Anti-markup

Contractors Affected

- Medicare Carriers
- Part A/B Medicare Administrative Contractors (A/B MACs)

Provider Types Affected

Physicians and other suppliers (such as physician organizations) submitting claims to Medicare Carriers and/or A/B MACs for diagnostic tests (excluding clinical diagnostic laboratory tests) provided to Medicare beneficiaries



- Change Request (CR) 6371 clarifies changes finalized in the Calendar Year (CY) 2009 Medicare Physician Fee Schedule (MPFS) final rule with comment related to diagnostic tests and the revised anti-markup provisions in Section 414.50 of Medicare regulations.
- In addition to providing instructions to the carrier or A/B MAC that describe how to apply the anti-markup payment limitation, it also provides instructions for determining when the anti-markup payment limitation applies and when it does not apply.

When Anti-markup Applies

Provider Needs to Know...

- The anti-markup payment limitation applies to tests formerly referred to as “purchased diagnostic tests.”
- Over time, the Centers for Medicare & Medicaid Services (CMS) will change all references to “purchased diagnostic tests” in Medicare manuals to “anti-markup test(s)”.

Until then, providers and their billing staffs should consider any reference to a “purchased diagnostic test” to be a reference to an anti-markup test.

- The anti-markup payment limitation applies when a diagnostic test (payable under the MPFS and excluding clinical diagnostic laboratory tests) is performed or supervised by a physician or other supplier who does not share a practice with the physician or other supplier that ordered and billed for the test.
- Payment to the billing physician or other supplier that ordered the test (less the applicable deductibles and coinsurance paid by or on behalf of the beneficiary) for the technical component (TC) or professional component (PC) of the diagnostic test may not exceed the lowest of the following amounts:
 - The performing supplier’s net charge to the billing physician or other supplier;
 - The billing physician or other supplier’s actual charge; or
 - The fee schedule amount for the test that would be allowed if the performing supplier billed directly (42 Code of Federal Regulations (CFR) 414.50 (a) (1)).
- The net charge must be determined without regard to any charge that reflects the cost of equipment or space leased to the performing supplier by the billing physician or other supplier (42 CFR 414.50(a)(2)(i)).
- The anti-markup payment limitation **will apply** in cases where a physician does not meet the criteria for satisfying the “substantially all services” test or the “site of service” test defined below.

When Anti-markup Does Not Apply

- The provision of Chapter 16, Section 40.2 of the *Medicare Claims Processing Manual* still applies. **Therefore, this new anti-markup provision does not apply to independent laboratories.**
 - The anti-markup payment limitation **will not apply** if the performing physician “shares a practice” with the ordering/billing physician or other supplier. As set forth in 42 CFR 414.50(a)(2), there are two alternatives for determining whether a performing/supervising physician shares a practice with the ordering/billing physician or other supplier:
 - **Alternative one: “Substantially all services requirement”**
 - If the performing physician (that is, the physician who supervises the TC or performs the PC, or both) furnishes substantially all (at least 75 percent) of his or her professional services through the billing physician or other supplier, the anti-markup payment limitation will not apply.
 - If the performing physician does not meet the “substantially all services” requirement, a “site of service” analysis may be applied on a test-by-test basis to determine whether the anti-markup payment limitation applies.
 - **Alternative two: “Site of service test”**
 - Only TCs conducted and supervised and PCs performed in the “office of the billing physician or other supplier” by a physician owner, employee or
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independent contractor of the billing physician or other supplier will avoid application of the anti-markup payment limitation.

- 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 regularly furnishes patient care. This includes space where the billing physician or other supplier furnishes diagnostic testing, if the space is located in the “same building” (as defined in 42 CFR 411.351) in which the ordering physician regularly furnishes patient care.
- If the billing physician or other supplier is a physician organization (as defined in 42 CFR 411.351), the “office of the billing physician or other supplier” is space in which the **ordering** physician provides substantially the full range of patient care services that the ordering physician generally provides.
- With respect to the TC, the performing supplier is the physician that supervised the TC and, with respect to the PC, the performing supplier is the physician that performed the PC. Therefore, if the “site of service” requirements are met, the anti-markup payment limitation will not apply.

Key Billing Points

- Medicare contractors will accept and process claims for either the TC or the PC of diagnostic tests (other than clinical diagnostic laboratory tests) submitted with the proper coding in the Purchased Service segments of the American National Standards Institute X12 837P electronic claim format.
 - More than one test subject to the anti-markup payment limitation may be submitted on the electronic claim. However, when billing such multiple tests, the total anti-markup service amount must be submitted for each service.
 - Medicare contractors will return claims as unprocessable if multiple anti-markup tests are submitted without line level anti-markup amount information included.
 - When billing using the form CMS-1500, each component of the test must be submitted on a separate claim form.
 - **For diagnostic test claims** submitted on a CMS-1500 Form, Medicare contractors will return as unprocessable those claims received with **more than one TC or PC service charge** when Item 20 of the 1500 Form is marked “YES.”
 - In returning such claims, Medicare contractors will use Reason Code 125 (“Submission/billing error(s)”) and Remittance Advice (RA) Remark Code M65 (“One interpreting physician charge can be submitted per claim when a purchased diagnostic test is indicated. Please submit a separate claim for each interpreting physician” when returning a claim as unprocessable”).
 - **For diagnostic test claims** submitted on a CMS-1500 Form, Medicare contractors will return as unprocessable those claims submitted with “YES” marked in Item 20 but **no charge amount entered**.
 - Medicare contractors will use Reason Code 16 (“Claim/service lacks information which is needed for adjudication”) and RA Remark Code MA111 (“Missing/incomplete/invalid purchase price of the test(s) and/or the performing
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laboratory's name and address.") when returning such a claim as unprocessable.

- For **diagnostic test claims** submitted on a CMS-1500 Form, Medicare contractors will return as unprocessable those claims received with the "YES" indicator checked and a **dollar amount in Item 20 but no location information** (name, address, city, state, and ZIP) for the physician/supplier from whom the diagnostic test was acquired in Item 32.
 - Medicare contractors will use Reason Code 16 ("Claim/service lacks information which is needed for adjudication") and RA Remark Code N294 ("Missing/incomplete/invalid service facility primary address") when returning a claim as unprocessable.

Background

- Section 1842(n)(1) of the Social Security Act requires CMS to impose a payment limitation on certain diagnostic tests where the physician performing or supervising the test does not share a practice with the billing physician or other supplier.
- Such a test was formerly referred to as a "purchased diagnostic test."
- In the CY 2009 MPFS final rule (73 FR 69799, November 19, 2008), CMS finalized changes to 42 CFR § 414.50 to include alternative methods to determine when not to apply anti-markup rules.

Operational
Impact

N/A

Reference
Materials

The related MLN Matters® article can be found at <http://www.cms.gov/MLN MattersArticles/downloads/MM6371.pdf> on the CMS website.

The official instruction (CR6371) issued regarding this change may be found at <http://www.cms.gov/Transmittals/downloads/R445OTN.pdf> on the CMS website.