



Payment to Physician or Other Supplier for Diagnostic Tests Subject to the Anti-Markup Payment Limitation – JA6733

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Key Words MM6733, CR6733, R1892CP, Payment, Diagnostic, Tests, Anti-Markup, Limitation

Contractors Affected

- Medicare Carriers
- Medicare Administrative Contractors (MACs)

Provider Types Affected Provider types affected are physicians and other suppliers (such as physician organizations) submitting claims to Medicare Carriers and/or MACs for diagnostic tests (excluding clinical diagnostic laboratory tests) provided to Medicare beneficiaries.



- Change Request (CR) 6733 alerts providers that the Centers for Medicare & Medicaid Services (CMS) is revising the section of the *Medicare Claims Processing Manual* to implement changes to 42 Code of Federal Regulations (CFR) Section 414.50 that were made in the calendar year (CY) 2009 Physician Fee Schedule final rule (73 FR 69799, November 19, 2008).
- These changes include two alternative methods for determining when not to apply the anti-markup payment limitation.
- CMS is replacing Section 30.2.9 and deleting Section 30.2.9.1 of Chapter 1, *Medicare Claims Processing Manual*, removing references to “purchased diagnostic test” and “purchased test interpretation” in the manual, and substituting references to the “anti-markup test.”

Note: When the anti-markup provision applies, it is applicable to the professional component (PC) as well as the technical component (TC) of a diagnostic test that is billed by a physician or other supplier that did not perform the test.

When the Anti-markup Payment Applies

- The anti-markup payment limitation applies:
 - When a diagnostic test, payable under the Medicare Physician Fee Schedule (MPFS), is performed by a physician who does not meet the requirements described in 42 Code of Federal Regulations (CFR) Section 414.50 and in the revised Section 30.2.9 of the *Medicare Claims Processing Manual* for “sharing a practice” with the billing physician or other supplier. Essentially, the anti-markup payment limitation will apply if the performing physician does not “share a practice” with the billing physician or other supplier who ordered the test.
- When the anti-markup payment limitation applies, payment to the billing physician or other supplier (less any applicable deductibles or coinsurance) for the TC or PC of the diagnostic test does 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; and
 - The MPFS amount for the test that would be allowed if the performing supplier had billed directly.
- The net charge must be determined without regard to any charge that reflects the cost of equipment or space leased to the performing physician.

Provider Needs to Know...

When the Anti-markup Payment Does Not Apply

- The anti-markup payment limitation will not apply:
 - If the physician or other supplier does not order the diagnostic test; or
 - If the performing/supervising physician is deemed to “share a practice” with the billing physician or other supplier.

Alternatives for Determining a "Shared practice"

- There are two alternative methods for determining whether the performing/supervising physician is deemed to “share a practice.” Those alternatives are:
 - **The “Substantially All Services” Test**
 - If the performing physician (the physician who supervises or conducts the TC, 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.
 - **The “Site of Service/same Building” Test**
 - If the TC or the PC is supervised/performed in the “office of the billing physician or other supplier” by a physician owner, employee, or independent contractor of the billing physician or other supplier, **the anti-markup payment limitation**
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will not apply.

- 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 services, if the space is located in the “same building” in which the ordering physician regularly furnishes patient care.
- If the billing physician or other supplier is a physician organization, 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 provides generally. With respect to the TC, the performing physician is the physician who conducted and/or supervised the TC, and with respect to the PC, the performing physician is the physician who personally performed the PC.

Key Billing Points

- The billing physician or other supplier must keep on file the name, the National Provider Identifier (NPI), and address of the performing physician. The physician or other supplier furnishing the TC or PC of the diagnostic test must be enrolled in the Medicare program. **No formal reassignment is necessary.**
- **NOTE:** When billing for the TC or PC of a diagnostic test (other than a clinical diagnostic laboratory test) that is performed by another physician, the billing entity must indicate the name, address, and NPI of the performing physician in Item 32 of the CMS-1500 claim form. However, if the performing physician is enrolled with a different B/MAC, the NPI of the performing physician is not reported on the CMS-1500 claim form. In this instance, the billing entity must submit its own NPI with the name, address, and ZIP code of the performing physician in Item 32 of the CMS-1500, or electronic equivalent, claim form. The billing supplier should maintain a record of the performing physician's NPI in the clinical record for auditing purposes.
- If the billing physician or other supplier performs only the TC or the PC and wants to bill for both components of the diagnostic test, the TC and PC must be reported as separate line items if billing electronically (American National Standards Institute X12 837) or on separate claims if billing on paper (CMS-1500). Global billing is not allowed unless the billing physician or other supplier performs both components.

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 Section 414.50 to include alternative methods to determine when not to apply anti-markup rules.
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Operational Impact	N/A
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Reference
Materials

The related MLN Matters® article can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6733.pdf> on the CMS website.

The official instruction (CR6733) issued regarding this change may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R1892CP.pdf> on the CMS website.

CR6371 is a related CR, which described the claims processing instructions for implementing the recent changes to the anti-markup payment limitation rules. The MLN Matters® article for CR 6371 may be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6371.pdf> on the CMS website.
