Medicare Learning Network
MLN Matters®
CMS
Information for Medicare Fee-for-Service Health Care Professionals

News Flash – A new MLN Matters article (MM6740) has been released on the subject of Revisions to Consultation Services Payment Policy. This article alerts physicians and non-physician practitioners that effective January 1, 2010, the Current Procedural Terminology (CPT) consultation codes (ranges 99241-99245 and 99251-99255) are no longer recognized for Medicare Part B payment. Effective for services furnished on or after January 1, 2010, physicians and non-physician practitioners should code a patient evaluation and management visit with E/M codes that represent where the visit occurs and that identify the complexity of the visit performed. For more information, please view the article located at ***http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6740.pdf*** on the CMS website.

MLN Matters® Number: MM6733
Related Change Request (CR) #: 6733
Related CR Release Date: January 15, 2010
Effective Date: March 15, 2010
Related CR Transmittal #: R1892CP
Implementation Date: March 15, 2010

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

Provider Types Affected

Physicians and other suppliers (such as physician organizations) submitting claims to Medicare contractors (carriers and/or Medicare Administrative Contractors (MACs)) for diagnostic tests (excluding clinical diagnostic laboratory tests) provided to Medicare beneficiaries.

Provider Action Needed

This article pertains to change request (CR) 6733 which 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 CFR section 414.50 that were made in the CY 2009 PFS 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. CR 6371 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. In order to make the regulatory changes, CMS is replacing section 30.2.9 and deleting section 30.2.9.1 of Chapter 1, *Medicare Claims Processing Manual.* CMS is also removing references of the terms "purchased diagnostic test" and "purchased test interpretation" in the manual and substituting references to the "anti-markup test." For those billing for these services, be sure to understand when the anti-markup limitation applies, as described in CR 6733.

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.

CR 6733 provides instructions for determining when the anti-markup payment limitation applies and when it does not apply.

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

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. When the anti-markup payment limitation applies, payment to the billing physician or other supplier (less any applicable deductibles or coinsurance) for the technical component (TC) or professional component (PC) of the diagnostic test may not exceed the lowest of the following amounts:
    1. The performing supplier's net charge to the billing physician or other supplier.
    2. The billing physician or other supplier's actual charge.
    3. 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.

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. There are two alternative methods for determining whether the performing/supervising physician is deemed to "share a practice." Those alternatives are:

Alternative one, "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.

Alternative two, "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 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 of CR 6733

- 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.
- If the anti-markup payment limitation applies, the billing physician or other supplier will be paid for the TC or PC of the diagnostic test (less any applicable deductibles or coinsurance) the lower of: (1) the performing

physician's net charge to the billing physician or other supplier; (2) the billing physician or other supplier's actual charge; or, (3) the MPFS amount for the test that would be allowed if the performing physician had billed directly.

- The anti-markup payment limitation will not apply if the performing/supervising physician "shares a practice" with the billing physician or other supplier.
- 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.
- If the TC or PC is supervised/performed in the "office of the billing physician or other supplier" or in the "same building" by a physician owner, employee, or independent contractor of the billing physician or other supplier, the anti-markup payment limitation will not apply.
- The billing physician or other supplier must keep on file the name, the National Provider Identifier, 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 (ANSI 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.

Additional Information

If you have questions, please contact your Medicare carrier and/or MAC at their toll-free number which may be found at ***http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*** on the CMS website.

The official instruction, CR6733, issued to your Medicare carrier and/or MAC regarding this change may be viewed at ***http://www.cms.hhs.gov/Transmittals/downloads/R1892CP.pdf*** on the CMS website. The revised portion of the Medicare Claims Processing Manual is attached to CR 6733.