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

Did you know that your local Medicare contractor (carrier, fiscal intermediary, or Medicare Administrative Contractor (MAC)) is a valuable source of news and information regarding Medicare business in your specific practice location? Through their electronic mailing lists, your local contractor can quickly provide you with information pertinent to your geographic area, such as local coverage determinations, local provider education activities, etc. If you have not done so already, you should go to your local contractor website and sign up for their listserv or e-mailing list. Many contractors have links on their home page to take you to their registration page to subscribe to their listserv. If you do not see a link on the homepage, just search their site for "listserv" or "e-mail list" to find the registration page. If you do not know the Web address of your contractor's homepage, it is available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

MLN Matters Number: MM6371
Related Change Request (CR) #: 6371
Related CR Release Date: February 13, 2009
Effective Date: July 1, 2009
Related CR Transmittal #: R445OTN
Implementation Date: July 6, 2009

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

Note: This article was revised on September 18, 2014, to add a reference to MLN Matters® article MM8806 available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8806.pdf** to alert physicians and suppliers billing anti-markup and reference laboratory claims that billing physicians are required to report the name, address, ZIP code and NPI of the performing physicians/supplier when they are enrolled in a different contractor's jurisdiction. All other information is unchanged.

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) 6371, which 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 the Medicare regulations. Although this article provides instructions to your carrier or 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. **(Note that 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, you and your billing staffs should consider any reference to a "purchased diagnostic test" to be a reference to an anti-markup test. Basically, the anti-markup provision applies when a physician or other supplier orders a diagnostic test (payable under the MPFS and excluding clinical diagnostic laboratory tests) and bills for the technical component (TC) or professional component (PC) of the test that is performed or supervised by a physician or other supplier who does not "share a practice" with the billing physician or other supplier that ordered the test. CR 6371 discusses some specific criteria that should be used to determine when the anti-markup payment limitation applies and when it does not apply. This new anti-markup provision does not apply to independent laboratories. The revisions in CR 6371 are summarized below in the Background and Key Billing Points sections of this article.

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.

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. 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**.** 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.
- The fee schedule amount for the test that would be allowed if the performing supplier billed directly (42 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 provision of Chapter 16, Section 40.2 of the "Medicare Claims Processing Manual" still applies, thus this new anti-markup provision does not apply to independent laboratories.

When anti-markup does not apply:
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. The two alternatives are:

- **Alternative one; substantially all services requirement:**
  Under the first alternative, 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:
  The second alternative is the "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 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. Thus, 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 technical component (TC) or the professional component (PC) of diagnostic tests (other than clinical diagnostic laboratory tests) submitted with the proper coding in the Purchased Service segments of the ANSI 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. When returning such a claim as unprocessable, 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 laboratory's name and address."
- 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.

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.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

You may want to review MLN Matters® article MM6627 for more current information regarding Medicare manual revisions regarding the removal of references to "purchased diagnostic tests." That article is available at **http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM6627.pdf** on the CMS website.

The official instruction, CR6371, issued to your Medicare carrier and/or MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R445OTN.pdf** on the CMS website.