CMS Makes Further Tweaks to the Medicare Anti-Markup Rule in the 2009 Proposed Medicare Physician Fee Schedule

By Victoria Heller Johnson, Esq.

In the final 2008 Medicare Physician Fee Schedule, the Centers for Medicare and Medicaid Services ("CMS") made dramatic changes to the Medicare anti-markup rule (contained at 42 C.F.R. § 414.50). Due to the controversial nature of several of the changes, on January 3, 2008, CMS announced in a final rule that it would postpone the effective date of the newly revised anti-markup rule until January 1, 2009, except with respect to the rule's application to anatomic pathology services (i.e., "pod labs") and the purchase of technical component services. In the proposed 2009 Medicare Physician Fee Schedule, CMS is yet again revisiting this topic with two new proposals for the applicability of the rule, as well as requests for comments on numerous related issues.

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Recent History of the Medicare Anti-Markup Rule

The Medicare anti-markup rule historically imposed a limitation upon the amount that could be billed by a physician or group for the technical component of diagnostic tests (excluding clinical diagnostic tests performed by clinical laboratories) that were performed by an outside supplier.

The 2007 Medicare Physician Fee Schedule contained a proposal to extend the anti-markup prohibition to the purchase of the professional component of diagnostic tests as well. The proposed revisions published at this time concentrated primarily on whether the person performing either the technical or professional component of the test was a full-time employee of the billing entity, as opposed to an independent contractor or part-time employee.

Based on comments received in response to these proposed revisions, CMS moved forward in the 2008 Medicare Physician Fee Schedule with the concept of extending the anti-markup prohibition to both the technical and professional components of diagnostic tests. However, the revised anti-markup rule contained in the 2008 Medicare Physician Fee Schedule eliminated the distinction surrounding whether the person performing either the technical or professional component of the diagnostic test was a full-time employee of the billing group versus an independent contractor or part-time employee. Instead, the revised rule focused on whether the technical or professional component of the diagnostic test was purchased from an outside supplier, or whether it was performed at a site other than the "office of the billing physician or other supplier".

Although significantly different from the proposed revisions contained in the 2007 Medicare Physician Fee Schedule, for which comments were solicited and received by CMS, the revised anti-markup rule contained in the 2008 Medicare Physician Fee Schedule was published in final form and was initially scheduled to go into effect on January 1, 2008. However, in response to numerous outcries from physician groups and other interested parties, CMS published a final rule released on January 3, 2008 in which it delayed the effective date of certain of the more controversial aspects of the revised rule, pending further clarification

and/or rulemaking by CMS.

On June 30, 2008, CMS released a copy of the proposed 2008 Medicare Physician Fee Schedule, which yet again revisits the controversial Medicare anti-markup rule. CMS is now proposing two different approaches to the anti-markup rule, and has solicited comments on the timing and other aspects of the rule.

Summary of the Medicare Anti-Markup Final Rule (as Published in the Final 2008 Medicare Physician Fee Schedule)

Under the 2008 Medicare Physician Fee Schedule, the revised anti-markup applies if a physician or other supplier bills Medicare for the technical or professional component of a diagnostic test that was ordered by the physician or other supplier (or a party related to the physician or supplier by common ownership or control), and the diagnostic test is either: (a) purchased from an outside supplier, or (b) performed at a site other than the office of the billing physician or other supplier. The anti-markup rule limits payment to the billing entity to the lowest of the following amounts:

(1) The outside supplier's net charge to the billing entity;
(2) The billing entity's actual charge; or
(3) The fee schedule amount that would be allowed if the outside supplier billed Medicare directly. (42 CFR §414.50(a)(1))

One of the more controversial aspects of the revised rule contained in the 2008 Medicare Physician Fee Schedule was the new definition that CMS created for the "office of the billing physician or other supplier". The term was defined as the "medical office space where the physician or other supplier regularly furnishes patient care". With regard to a physician organization, the term was further defined as the space where the physician organization provides "substantially the full range of patient care services that the physician organization provides generally". This definition would have subjected to the anti-markup rule diagnostic testing arrangements that were in compliance with the "same building" and "centralized building" approaches to the Stark in-office ancillary services exception. Numerous complaints regarding this perhaps unintended consequence prompted CMS to delay the effective date of the revised rule until January 1, 2009, except with respect to pod labs and the purchase of technical component services, as noted above.

In another controversial move, CMS introduced the concept of limiting the amount of payment to the outside supplier's "net charge" to the billing entity. Crafted to prevent what CMS called "gaming", CMS defined "net charge" as exclusive of any amount that takes into effect the costs for equipment or space that is leased by the billing entity to the outside supplier. The effect of this provision was that a billing entity could no longer factor into its fee schedule certain costs to the entity in providing the technical or professional component of diagnostic tests, such as costs for equipment and supplies needed to perform the tests or overhead costs where the diagnostic test was performed at a location other than the billing entity's office.

Two Alternative Approaches for the Rule Contained in the Proposed 2009 Medicare Physician Schedule

CMS is now proposing two alternative approaches for the Medicare anti-markup rule. Under the first approach, the anti-markup rule would apply where the professional component or the technical component of a diagnostic test is either (i) purchased from an outside supplier; or (ii) performed or supervised by a physician who does not share a practice with the billing physician or organization. Under this proposal, if a physician

is an employee (whether full-time or part-time) or an independent contractor of a single medical practice (which is the billing organization), the anti-markup rule would not apply. The rule would apply, however, in the event that a physician is an employee or independent contractor of more than one billing organization. CMS acknowledges that an exception may be needed in order to permit physicians to provide occasional services outside of their physician organization, such as locum tenens coverage, without the arrangement violating the "sharing a practice" component of the rule, and is soliciting feedback on this issue.

Under the second approach, CMS is proposing to retain the "site-of-service" approach outlined in the 2008 Medicare Physician Fee Schedule (as outlined above), but clarify what constitutes the "office of the billing supplier" and other pertinent defined terms. The anti-markup rule would continue to apply to the technical and professional components of non-purchased tests that are performed outside the "office of the billing supplier".

CMS has requested comments on which of the two approaches to use, or whether a different approach should be employed altogether.

Clarification as to What Constitutes the "Office of the Billing Supplier"

Under the second site-of-service approach, CMS is proposing to clarify this defined term to include space in which diagnostic testing is performed that is located in the same building in which the billing physician or supplier regularly furnishes patient care (and for physician organizations, in the same building where the ordering physician provides substantially the full range of patient care services that the ordering physician provides generally). This would exclude services provided in a mobile vehicle, van or trailer. CMS also clarifies that a physician may have more than one office in which he or she regularly furnishes patient care. Further, in response to comments that a multi-specialty group may provide substantially the full range of services at multiple locations, CMS is proposing to clarify that with respect to a physician organization, the defined term will include space in which diagnostic testing is performed that is located in the same building where the ordering physician provides substantially the full range of patient care services that the ordering physician provides generally.

While this approach essentially adopts the "same building" approach under the Stark in-office ancillary services exception, it notably does not adopt the "centralized building" approach under that exception, and may have an adverse effect on large multi-site group practices that provide diagnostic testing services in a centralized location. Acknowledging that this may be an issue, CMS has solicited comments as to whether an exception should be made for large group practices with multiple offices on the same medical or hospital campus where the group has consolidated its diagnostic testing. This exception, however, would do little to help group practices that have practice sites located across multiple cities or counties. CMS has also proposed making an exception to the rule for diagnostic tests ordered by a physician in a nonprofit physician organization.

Clarification as to "Performance" at a Site other than the Office of the Billing Physician or other Supplier.

The anti-markup rule applies to the technical component of a diagnostic test that is "performed" outside of the office of the billing physician or outside supplier. CMS is proposing to clarify that, if either the conducting of the technical component or its supervision by a physician is performed at a location outside of the billing physician/supplier's office, the anti-markup rule will apply.

Clarification as to What Constitutes Purchase from an Outside Supplier

CMS is requesting comments on what would constitute the purchase of a diagnostic test from an "outside supplier" for purposes of the anti-markup rule. It is proposing that the technical component of a diagnostic test would not be considered to have been purchased from an outside supplier in the event that the technical component is supervised and conducted within the office of the billing physician/supplier, and the supervising physician is an employee or independent contractor of the billing physician/supplier. CMS also proposed an alternative approach pursuant to which the test would be considered purchased if it is performed by a technician who is not an employee of the billing physician/supplier, regardless of where the test is performed or where the supervision occurs.

Definition of "Net Charge"

CMS is also re-examining the controversial definition of the outside supplier's "net charge" to the billing entity. CMS is proposing to clarify that where the anti-markup rule applies, the "net charge" for purposes of the professional component, is the charge of the interpreting physician, and for purposes of the technical component, is the charge of the supervising physician. While this approach appears to be fairly straightforward in connection with the professional component, it presents some difficulties in connection with the technical component, as practices and payors generally do not compensate physicians on a separate basis for the supervision of diagnostic tests.

Requests for Additional Comments

In the proposed 2009 Medicare Physician Fee Schedule, CMS has specifically requested guidance as to the following issues:

- How the "net charge" should be calculated and whether suppliers should be permitted to recoup certain overhead costs in connection with diagnostic tests
- Whether in lieu of or in addition to the anti-markup rule, CMS should prohibit reassignment in certain instances and require the physician supervising the technical component or performing the professional component to bill Medicare directly
- Whether CMS should delay the January 1, 2009 effective date for some or all of the revisions to the anti-markup rule contained in the 2008 Medicare Physician Fee Schedule or any proposed revisions to that rule which may become finalized before that date.

The deadline for submitting comments to the proposed 2009 Medicare Physician Fee Schedule is August 29, 2008.

Stay Tuned

As discussed above, the anti-markup rule published in the final 2008 Medicare Physician Fee Schedule significantly differed from the proposed rule published in the 2007 Medicare Physician Fee Schedule. It remains to be seen whether a similar outcome will result this time around. Providers of diagnostic testing services are advised to continue monitoring the situation as the Medicare anti-markup rule continues to evolve.

Billing Tip of the Month:

Welcome to our new regular billing & coding tip column by Michelle M. Rimmer, CHI.

Each month Michelle will offer a regular billing & coding tips, which can be found online at www.billing-coding.com/tips and provide a regular tip in each issue of BC Advantage magazine.

We encourage you to also email Michelle at Michelle@pmbausa.com with any questions or comments and visit her web site www.pmbausa.com

Medicare claims rejecting for inaccurate placement of the NPI?

If you are billing for a solo practitioner and you are placing the individual rendering physician's NPI in block 24J–this could be the reason your claims are rejecting!

Medicare requires that block 24J be left blank when billing for a solo practitioner. The individual rendering physician's NPI should only be placed in block 24J when billing for a 'group entity'. When the data listed in block 33 is that for a 'group', then, and only then should block 24J be used.

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