



CMS' Anti-markup Rule

The Centers for Medicare & Medicaid Services (CMS) recently issued Transmittal 445 to provide claims processing instructions for contractors when submitting claims for diagnostic tests subject to the anti-markup payment limitation.¹

Effective July 1, 2009, CMS' contractors will process claims submitted for diagnostic testing services in accordance with the anti-markup provisions outlined in the 2009 Medicare Physician Fee Schedule (MPFS) final rule (published November 19, 2008). Under the 2009 MPFS final rule, CMS amended and expanded the payment limitations for diagnostic tests. The provisions are anticipated to reduce the likelihood of physicians "marking up" the prices billed to Medicare for diagnostic tests performed and interpreted by a third party (i.e. preventing physicians from billing Medicare for diagnostic services he/she did not render but rather were ordered and furnished by an outside supplier). The new anti-markup rule became effective January 1, 2009 and required physicians and other suppliers (e.g. physician organizations) to evaluate their diagnostic testing and billing arrangements to ensure compliance with the anti-markup rule.

Although the anti-markup provisions have been in effect since the beginning of this year, physicians and suppliers submitting Medicare claims for diagnostic tests should reexamine billing arrangements in light of the recent release of CMS' claims processing instructions to Medicare contractors. Physicians and suppliers who fail to comply with the anti-markup payment limitation will not only risk submission of a false claim, but may also be sanctioned under civil monetary penalty laws and mandated to be excluded from participating in federal programs.

What is the Anti-markup Rule?

The anti-markup rule is a price limitation for diagnostic services (technical and professional components) that are ordered by a physician or supplier and provided by a third party.² More specifically, under section 1842(n)(1) of the Social Security Act, CMS is required to enforce a payment restriction on diagnostic tests "where the physician performing or supervising the test does not share a practice with

¹ Note: The anti-markup provisions outlined in the 2009 Medicare Physician Fee Schedule do not apply to clinical diagnostic laboratory tests reimbursed under the Clinical Laboratory Fee Schedule.

² Providers are permitted to bill Medicare the technical and professional components of a diagnostic test. The technical component is the performing and/or supervisions of the diagnostic test while the professional component is the interpretation of the diagnostic test.

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the billing physician or other supplier.”^{3,4} Essentially, the anti-markup rule prevents a medical practice from profiting from diagnostic tests when diagnostic services were not performed, supervised or interpreted by the ordering physician. This is achieved by requiring physicians to bill Medicare the lowest of the following amounts for the diagnostic test:

- The performing supplier’s net charge (less the cost of equipment or space leased to the performing supplier) to the billing physician or supplier;
- The billing physician or supplier’s actual charge; or
- The fee schedule amount of the diagnostic test that would be permitted if the performing supplier billed Medicare directly.

Prior to the issuance of the 2009 MPFS final rule, only the technical component of the diagnostic test was subjected to a price limitation if the test was performed in a location outside the office of the billing physician (i.e. performed by physician who does not share a practice with the ordering/billing physician). However, under the 2009 MPFS final rule, the reimbursement constraints were expanded to include the professional component. Thus, to avoid the anti-markup rule the performing physician providing the technical and professional components of the diagnostic test must “share a practice with the ordering/billing physician or supplier.”⁵

When does the Anti-markup Rule Apply?

Determining if the anti-markup rule applies is complex. CMS has created two alternatives to determine whether the anti-markup rule applies:

- Alternative One; substantially all services requirement: If the physician who supervises the technical component, performs the professional component, or does both, furnishes at least 75 percent of his/her professional services through the billing physician or supplier, then the diagnostic services will not be subjected to the anti-markup payment limitation.

In the event the performing physician does not meet the “substantially all services” requirement, the “site of service” test may be applied on a test-by-test basis.

- Alternative Two; site of service test: If the technical component is conducted and supervised and the professional component is performed “in the office of the billing physician or other supplier by a physician owner, employee or independent contractor of the billing physician

³ CMS, MLN Matters: Claims Processing Instructions for Diagnostic Tests Subject to the Anti-Markup Pricing Limitation, MM6371, CR 6371 (Feb. 13, 2009).

⁴ Note: Diagnostic tests subject to the anti-markup rule were formerly referred to as “purchased diagnostic test.” CMS has changed the term to “anti-markup test.” Although, the term has not been completely revised in CMS Internet Manuals, readers should reference “purchased diagnostic test” as “anti-markup test.”

⁵ CMS, MLN Matters: Claims Processing Instructions for Diagnostic Tests Subject to the Anti-Markup Pricing Limitation, MM6371, CR 6371 (Feb. 13, 2009).

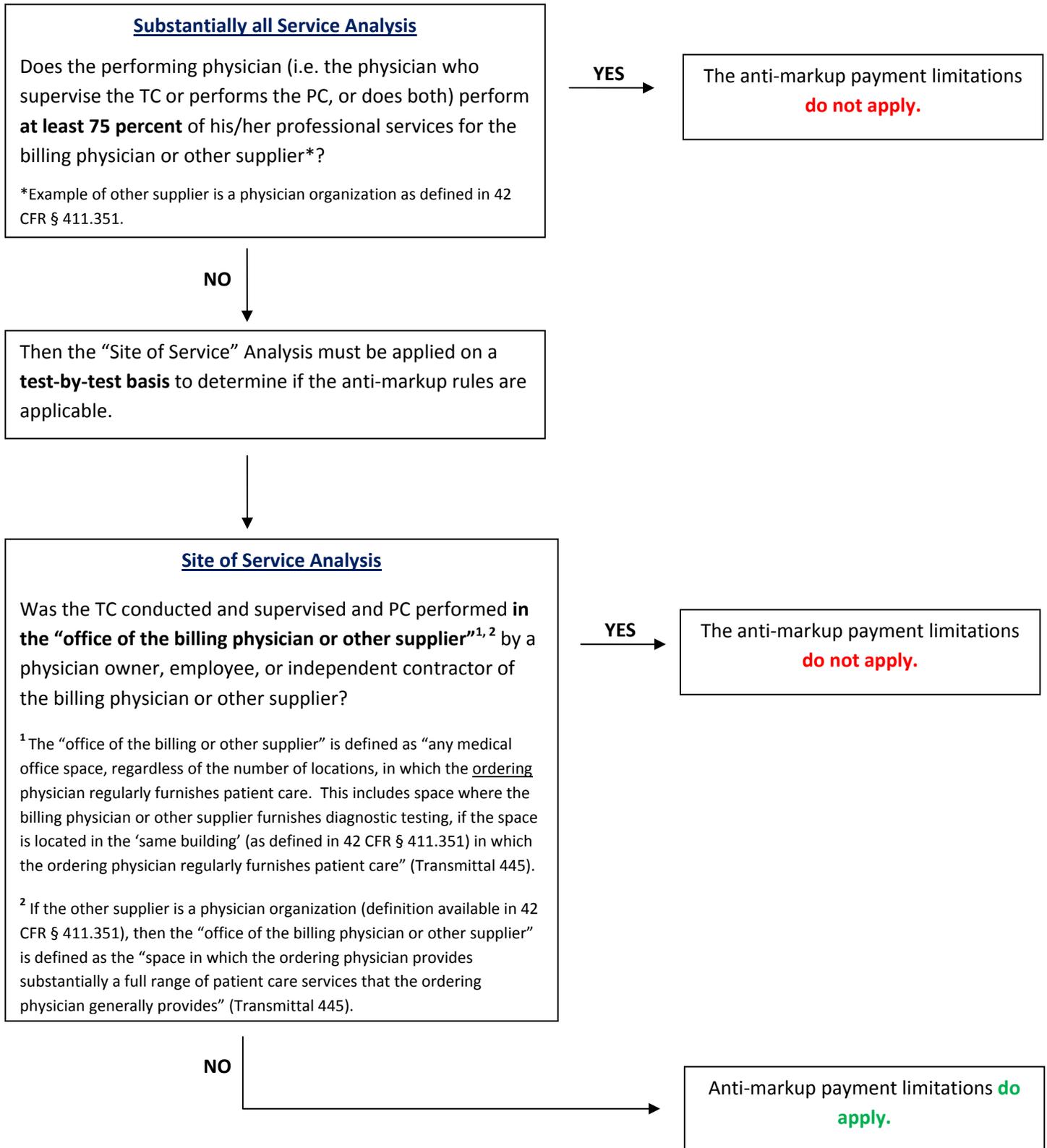
or other supplier,” then the diagnostic services will not be subjected to the anti-markup payment limitation.⁶

Thus, if a diagnostic test does not meet the “substantially all services” requirement or the “site of service” test the anti-markup rule will apply. The physician will be required to bill Medicare the lower of either the performing supplier’s net charge; the billing physician or supplier’s actual charge; or the fee schedule amount for the test that would be permitted if the performing provider directly billed CMS.

Figure 1 provides a flowchart to assist in determining the application of the anti-markup rule.

⁶ CMS, Claims Processing Instructions for Diagnostic Tests Subject to the Anti-Markup Pricing Limitation, Trans. 445, CR 6371 (Feb. 13, 2009).

Figure 1: Will the Anti-markup Payment Limitation Apply?



What are the key billing issues for diagnostic tests subject to the anti-markup rule?

When submitting claims for diagnostic services compliance officers and billing personnel should consider the following:

- **Use the correct modifiers.** When submitting claims for diagnostic tests, modifier TC must be appended for the technical component and modifier 26 for the professional component to the appropriate CPT/HCPCS code. These modifiers should be reported in the “Purchase Service” segments of the ANSI X12 837P electronic claim form and in Item 24 on the CMS-1500 paper form.
- **Submit separate claims.** When using the CMS-1500 form, the technical and professional components must be reported on separate claim forms. Failure to submit separate claims for the technical and professional components of the diagnostic service will result in a returned claim with Reason Code 125 (Submission/billing error) and Remittance Advice 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).
- **Bill multiple tests properly.** CMS permits providers to submit more than one diagnostic test that is subjected to the anti-markup payment limitation in the electronic claim form. When submitting claims for multiple tests, the total anti-markup amount should be reported for each service. Failure to provide the total anti-markup amount will result in an unprocessable claim and Medicare contractors will return the claim to the provider.
- **Review CMS-1500 Item 20.** Medicare contractors will return claims as unprocessable if “YES” is selected in Item 20 and no charge amount is entered. Providers will receive Reason Code 16 (Claim/service lacks information which is needed for adjudication) and Remittance Advice Remark Code MA11 (Missing/incomplete/invalid purchase price of the test(s) and/or the performing laboratory’s name and address). Moreover, contractors will also return claims as unprocessable if “YES” is selected in Item 20 and the location information (name, address, city, state, and ZIP) for the physician/supplier is not reported in Item 32. Providers will receive Reason Code 16 and Remittance Advice Remark Code N294 (Missing/incomplete/invalid service facility primary address).

The key aspects of the anti-markup rule are the individual who performs the diagnostic test and the place where the diagnostic test is conducted. If the ordering physician bills Medicare for the technical and/or professional components of a diagnostic test and the test is performed outside the office of the billing physician or by a supplier who is not an employee of the billing physician, then the anti-markup rule applies.

As noted above, providers are strongly encouraged to reevaluate diagnostic tests and billing arrangements. If questions do arise, compliance officers and billing personnel should contact their Medicare contractor. Since the anti-markup rule has been effective since January 1, 2009, providers should immediately implement appropriate measures to ensure compliance with the anti-markup rule.

Resources

- 42 CFR §414.50.
- Social Security Act §1842(n)(1).
- Medicare Program: Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2009; E Prescribing Exemption for Computer Generated Facsimile Transm, 73 Fed. Reg. 69799 (Nov. 19, 2008).
- CMS, Claims Processing Instructions for Diagnostic Tests Subject to the Anti-Markup Pricing Limitation, Trans. 445, CR 6371 (Feb. 13, 2009).
- CMS, MLN Matters: Claims Processing Instructions for Diagnostic Tests Subject to the Anti-Markup Pricing Limitation, MM6371, CR 6371 (Feb. 13, 2009).