CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1892	**Date: January 15, 2010**
	Change Request 6733

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

I. SUMMARY OF CHANGES: This Change Request (CR) is revising Chapter 1, section 30.2.9 and deleting section 30.2.9.1, of Publication 100-04, Claims Processing Manual. In addition, this CR is removing references of the term "purchased diagnostic test" and "purchased test interpretation" and replacing those terms with "anti-markup test" or "diagnostic tests subject to the anti-markup payment limitation."

New / Revised Material
Effective Date: March 15, 2010
Implementation Date: March 15, 2010

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	1/30.2.9/Payment to Physician or Other Supplier for Diagnostic Tests Subject to the Anti-Markup Payment Limitation-Claims Submitted to A/B MACs
D	1/30.2.9.1/Payment to Supplier of Diagnostic Tests for Purchased Interpretations

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1892	Date: January 15, 2010	Change Request: 6733

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

Effective Date: March 15, 2010.

Implementation Date: March 15, 2010.

I. GENERAL INFORMATION

A. Background: Section 1842(n)(1) of the Social Security Act requires CMS to impose an anti-markup payment limitation on diagnostic tests described in section 1861(s)(3) (other than clinical diagnostic laboratory tests) where the physician performing or supervising the test does not share a practice with the billing physician or other supplier. This contractual billing arrangement was formerly referred to as a "purchased diagnostic test," which is codified in 42 CFR § 414.50 and is also referenced in Chapter 1, section 30.2.9 of Publication 100-04, Claims Processing Manual.

In the CY 2008 Physician Fee Schedule (PFS) final rule (72 FR 66222), CMS expanded the anti-markup payment limitation described in 42 CFR § 414.50 to: (1) include a situation where the technical component (TC) of a diagnostic test is not performed in the "office of the billing physician or other supplier"; and (2) to impose an anti-markup payment limitation on the professional component (PC) of a diagnostic test ordered by the billing physician or other supplier if the PC is acquired by contractual arrangement or if the PC if not performed in the office of the billing physician or other supplier. However, CMS delayed implementation of the new anti-markup provisions in 72 FR 66222, in a subsequent final rule (73 FR 405), in order to further study health care industry concerns.

As a result of further study, CMS finalized changes to 42 CFR § 414.50 in the CY 2009 PFS final rule (73 FR 69799, November 19, 2008), to include two alternative methods for determining when not to apply the anti-markup payment limitation. To effectuate this regulatory change, we are replacing Chapter 1, section 30.2.9 and deleting section 30.2.9.1 of Publication 100-04, Claims Processing Manual. Further, CMS is removing references of the terms "purchased diagnostic test" and "purchased test interpretation" in the internet-only manual and substituting references to the "anti-markup test."

B. Policy:

When the anti-markup payment limitation applies:

The anti-markup payment limitation applies when a diagnostic test, payable under the Medicare Physician Fee Schedule, is performed by a physician who does not meet the requirements, described in 42 CFR § 414.50 and in Chapter 1, section 30.2.9 of Publication 100-04, 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 TC or 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 physician fee schedule 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. (See 42 CFR § 414.50(a)(2)(i).)

When the anti-markup payment limitation does not apply:

The anti-markup payment limitation will not apply, 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."

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. If the performing physician does not meet the "substantially all services" requirement, a "site of service/same building" analysis may be applied on a test-by-test basis to determine whether the anti-markup payment limitation applies.

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" (see §414.50(A)(2)(B)) 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" (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 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.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6733.1	Contractors shall refer to Chapter 1, section 30.2.9 of Publication 100-04, Claims Processing Manual for information regarding the application of the anti-markup	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	payment limitation.										
6733.2	Contractors shall be aware that the anti-markup payment limitation applies to the professional component, as well as to the technical component of a diagnostic test that is billed by a physician or other supplier that did not perform the test.	X			X						
6733.3	Contractors shall be aware that the anti-markup payment limitation may apply to the technical component and/or professional component of a diagnostic test that formerly was billed as a "purchased test" or as a reassignment.	X			X						
6733.4	Contractors shall be aware that the anti-markup payment limitation applies if the performing physician does not "share a practice" with the billing physician or other supplier that ordered the test.	X			X						
6733.5	Contractors shall be aware that the anti-markup payment limitation does not apply if the physician or other supplier does not order the diagnostic test.	X			X						
6733.6	Contractors shall not be required to determine whether the anti-markup payment limitation applies or does not apply when processing claims.	X			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6733.7	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

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X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): David Walczak (410) 786-4475

Post-Implementation Contact(s): David Walczak (410) 786-4475

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs),* include the following statement:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be

outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

Table of Contents
(Rev. 1862, 01-15-10)

30.2.9 - Payment to Physician or Other Supplier for Diagnostic Tests *Subject to the Anti-Markup Payment Limitation- Claims Submitted to A/B MACs –*

(Rev. 1892; Issued: 01-15-10; Effective/Implementation Date: 03-15-10)

A physician or other supplier may bill for the technical component (TC) and/or professional component (PC) of a diagnostic test that was ordered by the physician or other supplier (or ordered by a party related to the billing physician or other supplier through common ownership or control), subject to an anti-markup payment limitation, if the diagnostic test is performed by a physician who does not "share a practice" with the billing physician or other supplier. (This claim and payment limitation does not apply to clinical diagnostic laboratory tests, which are paid under the Clinical Laboratory Fee Schedule.) Under the anti-markup payment limitation, payment to the billing physician or other supplier (less the deductibles and coinsurance paid by the beneficiary or on behalf of the beneficiary) for the TC or 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. (With respect to the TC, the performing supplier is the physician who supervised the test, and with respect to the PC, the performing supplier is the physician who performed the PC.);*

(2) The billing physician or other supplier's actual charge; and

(3) The fee schedule amount for the test that would be allowed if the performing supplier billed directly. (See section 10.1.1.2 for information on payment jurisdiction for services subject to the anti-markup payment limitation.)

** The net charge must be determined without regard to any charge that is intended to reflect the cost of equipment or space leased to the performing supplier by or through the billing physician or other supplier.*

Exception to the Anti-markup Payment Limitation

If the performing physician is deemed to "share a practice" with the billing physician or other supplier (who ordered the test), the anti-markup payment limitation does not apply. A performing physician is considered to "share a practice" with the billing physician or other supplier if the performing physician furnishes "substantially all" (at least 75 percent) of his or her professional services through the billing physician or other supplier. The "substantially all" services requirement will be satisfied, if, at the time the billing physician or other supplier submits a claim for a service furnished by the performing physician, the billing physician or other supplier has a reasonable belief that: (1) for the 12 months prior to and including the month in which the service was performed, the performing physician furnished substantially all of his or her professional services through the billing physician or other supplier; or (2) the performing physician will furnish substantially all of his or her professional services through the billing physician or other supplier for the next 12 months (including the month in which the service is performed).

If the performing physician does not meet the "substantially all" services test, the performing physician may be deemed to "share a practice" with the billing physician or other supplier if the arrangement complies with a "site of service/same building" test. This alternative approach requires the performing physician to be an owner, employer, or independent contractor of the billing physician or other supplier and requires that the TC or PC be performed "in the office of the billing physician or other supplier." 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 or other supplier regularly furnishes patient care, and includes space where the billing physician or other supplier furnishes diagnostic testing services, if the space is located in the "same building" (as defined in 42 CFR §411.351 of the physician self-referral rules) in which the ordering physician or other ordering supplier regularly furnishes patient care. With respect to a billing physician or other supplier that is a physician organization (as defined in 42 CFR §411.351 of the physician self-referral rules), 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 the ordering physician provides generally. The performance of the TC includes, both, the conducting of the TC as well as the supervision of the TC.

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 Form 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 Form 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 Form 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 (Form CMS-1500). Global billing is not allowed unless the billing physician or other supplier performs both components.

Effective for claims received on or after April 1, 2004:
In order to have appropriate service facility location ZIP code and the acquired price of each test on the claim, when billing for *anti-markup* tests on the Form Form CMS-1500 paper claim form each test must be submitted on a separate claim form. Treat paper claims submitted with more than one *anti-markup* test as unprocessable per §80.3.2.

More than one *anti-markup* test may be billed on the ANSI X12N 837 electronic format. When more than one test is billed, the total *acquired* amount must be submitted for each service. Treat claims received with multiple *anti-markup* tests without line level total *acquired* amount information as unprocessable per §80.3.2.

Treat paper claims submitted for *anti-markup tests* with both the *technical component (TC) and the professional component (PC)* on one claim as unprocessable per §80.3.2 unless the services are submitted with the same date of service and same place of service codes. When a claim is received that includes both services, and the date of service and place of service codes match, assume that the one address in Item 32 applies to both services. Effective for claims with dates of service on or after April 1, 2005, each component of the test must be submitted on a separate claim form. Treat paper claims with dates of service after March 31, 2005 submitted with more than one *anti-markup* test as unprocessable per §80.3.2.

ANSI X12N 837 electronic claims submitted for *anti-markup tests* with both the *TC and the PC* on the same claim must be accepted. Assume that the claim level service facility location information applies to both services if line level information is not provided.

In order to price claims correctly and apply *anti-markup payment* limitations, global billing is not acceptable for claims received on the Form CMS-1500 or on the ANSI X12N 837 electronic format. Each component must be billed as a separate line item (or on a separate claim per the limitations described above). Treat the claim as unprocessable per §80.3.2 when a global billing is received and there is information on the claim that indicates the test was *acquired*.

Effective for claims with dates of service on or after January 25, 2005, *A/B MACs* must accept and process claims for diagnostic tests *subject to the anti-markup payment limitation* when billed by suppliers (including laboratories, physicians, and independent diagnostic testing facilities [IDTFs]) enrolled in the *A/B MAC's* jurisdiction, regardless of the location where the service was furnished. Effective April 1, 2005, carriers must price *anti-markup* test claims based on the ZIP code of the location where the service was rendered when billed by a laboratory or an IDTF, using a CMS-supplied national abstract file of the MPFS containing the HCPCS codes that are payable under the MPFS as either a *TC or PC of a diagnostic test subject to the anti-markup payment limitation* for the calendar year. Effective for claims with dates of service on or after October 1, 2007, *A/B MACs* must use the national abstract file to price all claims for diagnostic *tests subject to an anti-markup payment limitation*, for all *supplier* specialty types (including physicians), based on the ZIP code of the location where the service was rendered, in accordance with the *A/B MAC* jurisdictional pricing rules specified in §10.1.1. (See IOM Publication 100-04, Chapter 23, §30.6, and Addendum for record layouts and instructions for downloading the Abstract File for Diagnostic Tests *Subject to the Anti-Markup Payment Limitation*.)

NOTE: As with all services payable under the MPFS, the ZIP code is used to determine the appropriate payment locality and corresponding fee for the *anti-markup test*. When a ZIP code crosses locality lines, CMS uses the dominant locality to determine the corresponding fee.