

Imaging Centers Billing for Out of State Interpretations Can Expect Claim Denials

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Effective March 15, 2010, pursuant to the Centers for Medicare and Medicaid Services' (CMS) update to the Medicare Claims Processing Manual addressing "Payment to Physician or Other Supplier for Diagnostic Tests Subject to the Anti-Markup Payment Limitation," among other actions, CMS has effectively eliminated an Independent Diagnostic Testing Facility's (IDTFs) or radiology group's ability to bill its local carrier (MAC) for interpretations performed by out of state physicians (the CMS Change Request). Rather, by operation of these Medicare changes and Medicare's claims processing system, these imaging suppliers must now either take reassignment and bill the MAC in the interpreting physician's jurisdiction (if and only if they are able to establish a practice location in that MAC jurisdiction for enrollment purposes), or have the interpreting physician bill directly for such services.

Unfortunately, for a substantial number of imaging suppliers that rely upon out of state teleradiology arrangements (eg, radiology groups and IDTFs, which are not subject to the anti-markup rule), the only way to ensure payment by CMS for claims associated with out of state interpretation services is to have the interpreting physician bill directly for his/her service—at least until the agency publishes guidance to redress this issue, according to our discussions with senior officials at CMS. The only other option available for imaging suppliers is to accept reassignment from out of state interpreting physicians; however, this will require the imaging supplier to be eligible for enrollment in the out of state MAC jurisdiction. Notably, the issue remains unclear whether an imaging supplier will be able to enroll in the other jurisdiction if the supplier does not have a practice location in that particular jurisdiction. CMS has stated that a supplier without a practice location established in the jurisdiction will not be accepted during the enrollment process. However, during our discussions with CMS, agency officials indicated they intend to issue further clarification on these issues. Imaging suppliers whose business operations are adversely affected by this recent CMS Change Request should remain alert for a future guidance on this issue by CMS in the form of another Change Request.

A brief overview of the CMS Change Request is described below.

Medicare Claims Processing Change Request 6733: Payment to Physician or Other Supplier for Diagnostic Tests Subject to the Anti-Markup Payment Limitation

On January 15, 2010, CMS released Change Request 6733, which updated the Medicare Claims Processing Manual (MCPM) to carry out regulatory changes that took effect in 2009 in connection with the expanded anti-markup payment limitation applicable to diagnostic tests under 42 CFR Section 414.50. While CMS explained that the primary intent of the Change Request was to implement the anti-markup regulatory changes, including the new alternative "sharing a practice" test approach, it also deletes references to "purchased test interpretations" and replaces the term with "anti-markup tests" or "diagnostic tests subject to the anti-markup payment limitation." These deleted and replaced references in the MCPM trigger the above referenced problems for radiology groups and IDTFs that had been considered to be "purchasing" interpretations from out of state physicians.

Specifically, for a number of years, CMS generally has permitted radiology groups and IDTFs to contract with interpreting physicians regardless of the interpreting physician's location and to bill the interpretation (together with the technical component that they furnished) to their MAC. The IDTF or radiology group would provide the zip code of the interpreting physician, enabling Medicare to pay the correct geographic practice cost index (referred to as Zip Code Billing). However, effective March 15, 2010, pursuant to Change Request 6733, this no longer is permitted due to deletion of the references to "purchased interpretations." Now only referring physician groups that bill for interpreting physicians who are "subject to the anti-markup payment limitation" (ie, the interpreting physician does not "share a practice" with the billing physician) can take advantage of this Zip Code Billing.

Thus, radiology groups and IDTFs utilizing teleradiology arrangements that cross different MAC jurisdictions have two options:

- (1) Take reassignment from the interpreting physician, then enroll and submit claims to that physician's MAC (if they can establish a practice location in that jurisdiction), or
- (2) Have the interpreting physician bill Medicare directly for his/her services.

Change Request 6733 also contains a number of important

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billing related principles of which physicians and suppliers ordering and billing for diagnostic tests should be cognizant:

- The anti-markup payment limitation will apply if the performing physician (ie, the supervising physician with respect to the TC and the interpreting physician with respect to the professional component [PC]) does not “share a practice” with the billing physician or other supplier who ordered the test. Note there are two alternative tests to determine if the physician is deemed to “share a practice:”

- The performing physician performs substantially all (ie, at least 75%) of his or her professional services for the billing physician or other supplier; or

- Only TCs conducted and supervised in, and PCs performed in, the “office of the billing physician” (which includes testing performed in the “same building” under Stark) by an employee, owner, or independent contractor physician will be deemed to “share a practice” with the billing physician or other supplier and will avoid application of the anti-markup payment limitation.

- If the anti-markup rule payment limitation applies, the billing physician or other supplier will be paid (less deductibles and co-pays) the lower of:

- 1) The performing physician’s or other supplier’s net charge to the billing entity;

- 2) The billing entity’s actual charge; or

- 3) The fee schedule amount for the test that would be allowed if the performing physician or supplier billed directly.

- The billing physician or other supplier must keep on file the name, NPI, and address of the performing physician. The physician or other supplier furnishing the TC or PC of the diagnostic tests must be enrolled in the Medicare program, although no formal reassignment is required.

- If the billing physician or other supplier performs only the TC or the PC and seeks to bill for both components of the diagnostic test, the TC and PC must be reported as separate line items if billing electronically, or on separate claims if billing on paper. Global billing is prohibited unless the billing physician or other supplier performs both components.

CMS has also issued an MLN Matters article which alerts providers that CMS is revising the MCPM to implement the anti-markup rule changes. The MLN Matters article can be found here: <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6371.pdf>. However, it remains uncertain at this time how CMS plans to address issues associated with Zip-Code Billing for imaging centers and radiology groups that utilize cross jurisdiction teleradiology arrangements. Although CMS would not speak to the timing of guidance on this issue, agency officials informally advised us that they are aware of the problems arising from this CMS Change Request. Thus, imaging suppliers should remain alert for future CMS clarification that hopefully will correct what are widely held to be the unintended effects of Change Request 6733.