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Revisions to Anti-Markup Rule for Purchased Diagnostic Tests: What You Don't Know Can Hurt You

On November 19, 2008, as part of the 2009 Medicare Physician Fee Schedule regulations, the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services ("CMS"), published final rules regarding payment limitations on diagnostic testing and the application of the "anti-markup" rules for diagnostic imaging services (the "2009 Rules"). The 2009 Rules became effective on January 1, 2009; however, anecdotal reports suggest that compliance thus far has been uneven.

Eric D. Fader, Counsel

Eric is a member of the Insurance & Reinsurance Department at Edwards Angell Palmer & Dodge LLP. He has more than 20 years' experience dealing with healthcare regulatory issues affecting physicians and other licensed providers, hospitals, management companies and insurers.

The original "anti-markup" rule, also known as the "purchased service" rule, came into effect in 1987 and prevented a medical practice from "marking up" the cost of a technical service that it purchased from an outside supplier. In the most common scenario, an internist in private practice who contracted with a company that provided portable ultrasound equipment was prohibited from billing the Medicare or Medicaid program for more than his actual cost for the leased equipment. In that same scenario, however, if the internist contracted separately with a radiologist to provide professional interpretations of the tests, the internist was permitted to "mark up" the professional fee – i.e., bill federal programs more than he paid the interpreting physician for the services. In recent years, CMS determined to eliminate the internist's ability to profit from work that he did not himself perform.

CMS rules permit physicians to bill Medicare and Medicaid for purchased diagnostic tests, so long as certain conditions are satisfied. Pursuant to Section 1842(n)(1) of the Social Security Act, payment for certain diagnostic tests may be limited when the physician performing or supervising the test does not "share a practice" with the physician or other supplier that bills for the test. Section 1842(n)(1) states that if a physician's bill for a diagnostic test does not indicate that the billing physician or another physician with whom the billing physician "shares a practice" personally performed or supervised the performance of the test, the amount payable for the test will be determined as follows:

(a) If the bill or request for payment indicates that the test was performed by a supplier, identifies the supplier, and indicates the amount the supplier charged the billing physician, payment for the test will be the lower of the actual acquisition cost for the test, or the supplier's reasonable charge for the test.

(b) If the bill or request for payment does not identify who performed the test, CMS will not pay for the test at all.

Clause (a) simply sets forth the long-standing "purchased service" rule. However, in the 2009 Rules, CMS applied a new definition of "sharing a practice" so as to extend the anti-markup provisions to professional services as well as the technical component of purchased diagnostic tests. There are two alternative methods of determining whether the anti-markup provisions apply:

(1) If the physician who performs the professional service or supervises the performance of the technical component of the test furnishes "substantially all" (75% or more) of his or her professional services through the billing physician or supplier, the anti-markup rule will not apply.

(2) If the performing physician does not meet the "substantially all" requirement of Clause (1), in order for the anti-markup rule not to apply, both the technical

component of the test and the professional interpretation must be physically performed in the office of the billing physician. "Office of the billing physician" is defined as space in which the billing physician regularly performs substantially the full range of patient care services that he normally provides. For this purpose, whether the performing physician is an employee of the billing physician or merely an independent contractor is irrelevant.

It should be noted that the above alternatives make it unnecessary to define such terms as "purchased diagnostic test" and "purchased interpretation." In the 2009 Rules, CMS focuses instead on whether the performance and interpretation of the test should be deemed to have truly occurred within the billing physician's practice; if not, he is no longer permitted to profit from either.

It is also important to note that the 2009 Rules apply the anti-markup rules even in situations in which the "self-referral" of the diagnostic imaging service is permitted under the "in-office ancillary services" exception to the Stark Law (which prohibits physicians from referring patients to related entities for various diagnostic and therapeutic health services).

In summary, if a billing physician supervises the performance of the technical component of a test, the anti-markup rule will not apply to the technical component, and if the interpreting physician's interpretation is performed in the office of the billing physician, the anti-markup rule will not apply to the professional component. In addition, so long as the requirements of the "in-office ancillary services" exception are satisfied, the Stark Law will not prohibit the arrangement.

An informal review of prevailing industry practice suggests that many physicians who have arrangements that are subject to the 2009 Rules have not yet modified such arrangements, either by (i) ensuring that the interpreting physician actually come to the billing physician's office to perform the professional interpretation, or (ii) refraining from "marking up" the billing physician's actual cost for the interpretation when billing federal programs. In failing to comply with the law, a physician would risk exclusion from the Medicare and Medicaid programs for up to five years and possible civil monetary penalties. It does not appear that federal regulatory authorities have yet initiated any concerted effort to enforce compliance with the 2009 Rules.

Over the past few decades, as federal healthcare regulation has become more extensive and complicated, states have often followed federal developments and enacted laws that resemble federal laws, notably in the self-referral and anti-kickback areas. The effect of this has generally been to take prohibitions that are applicable to billing under federal programs and expand them to all healthcare services provided within that state's borders, irrespective of the identity of the reimbursing entity. In addition, private insurance carriers have sometimes adopted their own coverage and reimbursement policies that have gone beyond state law and perhaps mirrored federal requirements. Now that the 2009 Rules have brought attention to the issue of physicians' profiting from the work of others with whom they are not truly affiliated, it would not be surprising to see states and private carriers begin to implement their own efforts to address this perceived problem.

Eric D. Fader, Counsel 212.912.2724 efader@eapdlaw.com