

## 2009 Medicare Physician Fee Schedule Revises Anti-Markup Rule

On October 30, 2008, the Centers for Medicare and Medicaid Services ("CMS") released the 2009 Medicare Physician Fee Schedule regulations. As part of these regulations, which are scheduled to be published in the Federal Register on November 19, 2008, CMS promulgated revised Medicare anti-markup rules, which will be applicable to all professional and technical component diagnostic services<sup>1</sup> effective January 1, 2009.

This Alert updates our July 2008 Alert that addressed proposals published on July 7, 2008, to revise the anti-markup rule and require physicians who provide diagnostic testing services to enroll as independent diagnostic testing facilities (IDTFs).

### Anti-Markup Rule

Last year, CMS issued new Medicare restrictions that would have expanded the purchased test regulation to prohibit a physician or other supplier from marking up the professional or technical component of any diagnostic test ordered by the physician or other supplier (or by a related party)

if the diagnostic test is either purchased from an outside supplier or performed at a site other than the office of the billing physician or supplier. CMS later modified this rule so that it applied only to anatomic pathology services and to the technical component of purchased diagnostic tests. The new rule will be effective for all diagnostic services, not only anatomic pathology services, as of January 1, 2009.

Pursuant to the new Medicare anti-markup rule, if a physician or other supplier bills for the professional or technical component of a diagnostic

test that was ordered by the physician or other supplier (or a related party through common ownership or control) and the diagnostic test is performed or supervised by a physician who does not "share a practice" with the billing physician or other supplier, the payment to the billing physician or supplier for the technical or professional component 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 supplier;
- 2) The billing physician or supplier's actual charge to the Medicare program; or
- 3) The Medicare fee schedule amount for the service that would be allowed if the performing supplier billed the service directly to the Medicare program.

The regulation now clarifies that with respect to the technical component, the "performing supplier" is the physician who supervised the technical component, and that the "performing supplier" for the professional component is the physician who performed the professional component.

<sup>1</sup> Clinical diagnostic laboratory tests, which are subject to special billing rules generally allowing payment only to the person or entity performing or supervising the test, are excluded from the anti-markup rule.

This change and related commentary from CMS indicate that the performing supplier's net charge will be regarded as the amount paid to the supervising or performing physician, but does not include any amounts paid directly to the technician who furnished the technical component. In addition, the regulations specify that 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 supplier.

CMS changed the standard for determining whether the anti-markup rule applies, so that physician practices and other suppliers who provide diagnostic testing services for their patients will now be able to avoid the anti-markup rule by satisfying either of two alternative standards for "sharing a practice." One alternative (designated by CMS in its commentary as "Alternative 1") focuses on whether the performing physician<sup>2</sup> furnishes at least 75% of his or her professional services through the billing physician or other supplier. The other alternative (labeled as "Alternative 2") focuses on where the diagnostic test is performed and supervised.

Under Alternative 1, a performing physician is deemed to share a practice with the billing physician or other supplier if the performing physician furnishes substantially all (at least 75%) of his or her professional services through the billing physician or supplier. This "substantially all" requirement will be satisfied if, at the time the billing physician or other supplier submits a claim for the 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 supplier, or (2) the performing physician will furnish substantially all of his or her professional services through the billing physician or supplier for the next 12 months (including the month in which the service is performed).

Under Alternative 2, a performing physician will be deemed to share a practice with the billing physician or other supplier if the performing physician is

an owner, employee, or independent contractor of the billing physician or supplier, and the professional or technical component is performed in the office of the billing physician or other supplier. The performance of the technical component is deemed to include both the conduct of the test by the technician and the supervision of the technical component by the performing physician. If the billing physician or other supplier intends to rely upon Alternative 2 with respect to the technical component of a diagnostic test the test must therefore be both conducted and supervised in office space satisfying this location test. The supervising physician is required to be present in the office of the billing physician or other supplier, presumably during all times when diagnostic tests are performed.

The rule sets forth a more stringent location standard for physician organizations than for other billing suppliers. With respect to a billing supplier that is not a physician organization, 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 ordering supplier regularly furnishes patient care. If the diagnostic test is billed by a physician

<sup>2</sup> With respect to the technical component, the physician supervising the test, and with respect to the professional component, the physician performing the professional component.

organization then the diagnostic test must be performed in space where the ordering physician provides substantially the full range of patient care services that the ordering physician provides generally. It is critical to note that under Alternative 2 a physician organization with multiple ordering physicians must meet this location requirement with respect to each physician for diagnostic tests that he or she orders. This location test includes space where the billing physician or supplier furnishes the diagnostic services, if the space is located in the “same building” (as defined under the Stark regulations) in which the ordering physician or ordering supplier regularly furnishes patient care, but not a centralized building that does not satisfy the same building standards<sup>3</sup>.

It is important for all physicians and other suppliers who bill for diagnostic services to consider the effect of the new anti-markup regulations. If the anti-markup regulations are applicable to a professional and/or technical component diagnostic service billed by

a physician or other supplier, the physician or other supplier must comply with the anti-markup regulation effective January 1, 2009, or modify the arrangement so that it does not implicate the anti-markup regulation.

### **IDTF Enrollment and Direct-Billing Requirements**

At this point CMS is not implementing its proposal to require physicians, nonphysician practitioners and their practice entities furnishing diagnostic testing services to enroll as IDTFs and be subject to various IDTF standards. CMS noted that Section 135 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) will require providers of the technical component of advanced diagnostic imaging services (such as diagnostic MRI, CT and nuclear medicine) to be accredited by January 1, 2012. CMS explained that it is deferring implementation of the proposed IDTF enrollment requirement while reviewing public comments and that it may revisit this issue.

CMS is extending the IDTF enrollment requirement to mobile diagnostic imaging providers and also is adding a requirement that mobile IDTFs bill directly for their mobile diagnostic Medicare services, other than hospital services provided “under arrangement.” CMS stated in its commentary that mobile providers leasing equipment and a technician will be required to bill directly. Mobile diagnostic imaging providers who lease equipment and technicians to physicians who supervise and bill for the diagnostic testing services, as well as the physicians entering into these transactions, should review their arrangements to determine whether these leases will need to be restructured or perhaps terminated in light of these new requirements.

\* \* \*

CMS is accepting comments to these final regulations through December 29, 2008.

If you have any questions regarding the new Medicare anti-markup regulations, please contact **Jane Pine Wood** at 508.385.5227, [jwood@mcdonaldhopkins.com](mailto:jwood@mcdonaldhopkins.com) or **Rick L. Hindmand** at 312.642.2203, [rhindmand@mcdonaldhopkins.com](mailto:rhindmand@mcdonaldhopkins.com).

<sup>3</sup> The commentary indicates that this provision applies to physician organizations, as well as other suppliers, though the rule is unclear in this regard.

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**Richard S. Cooper**, Chair  
Healthcare Practice Group  
216.348.5438  
rcooper@mcdonaldhopkins.com

**Paul N. Edwards**  
216.348.5432  
pedwards@mcdonaldhopkins.com

**Victor T. Geraci**  
216.430.2026  
vgeraci@mcdonaldhopkins.com

**Steven M. Harris**  
312.280.0111  
sharris@mcdonaldhopkins.com

**Rick L. Hindmand**  
312.642.2203  
rhindmand@mcdonaldhopkins.com

**Mark D. Klimek**  
216.348.5453  
mklimek@mcdonaldhopkins.com

**Anthony D. Konkoly**  
216.348.5746  
akonkoly@mcdonaldhopkins.com

**James W. Marks**  
312.280.0111  
jmarks@mcdonaldhopkins.com

**John T. Mulligan**  
216.348.5435  
jmulligan@mcdonaldhopkins.com

**Jeffrey D. Schmidt**  
312.280.0111  
jschmidt@mcdonaldhopkins.com

**Jane Pine Wood**  
508.385.5227  
jwood@mcdonaldhopkins.com

**Melissa Asbrock**  
216-348-5740  
masbrock@mcdonaldhopkins.com

**Susan McGlone**  
216-430-2022  
smillradt@mcdonaldhopkins.com

**Todd Sarver**  
614-458-0042  
tsarver@mcdonaldhopkins.com

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*Business Law / Litigation / Business Restructuring / Estate Planning and Probate*

Chicago  
640 N. LaSalle Street  
Suite 590  
Chicago, IL 60654  
312.280.0111

Cleveland  
600 Superior Avenue, East  
Suite 2100  
Cleveland, OH 44114  
216.348.5400

Columbus  
41 South High Street  
Suite 3550  
Columbus, OH 43215  
614.458.0025

Detroit  
(McDonald Hopkins PLC)  
39533 Woodward Avenue  
Suite 318  
Bloomfield Hills, MI 48304  
248.646.5070

West Palm Beach  
505 S. Flagler Drive  
Suite 300  
West Palm Beach, FL 33401  
561.472.2121