Summary of the Final Rule on the 2009 Medicare Physician Fee Schedule

The Centers for Medicare and Medicaid Services (CMS) released the review copy of the 2009 Medicare Physician Fee Schedule (MFS) final rule on Oct. 30, 2008. The federal register copy was published on Nov. 19, 2008. The ACR will submit comments to CMS by Dec. 29, 2008. Following are the highlights of the final rule.

A. Independent Diagnostic Testing Facilities

CMS proposed that all physician and non-physician practitioner (NPP) organizations providing diagnostic imaging services to enroll as an IDTF for each practice location providing these services (diagnostic mammography is excluded). In the final rule, CMS defers the implementation of the proposal with the enactment of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) legislation and its requirements that non-hospital imaging be accredited by 2012. They will continue to review comments received and will consider finalizing the provision in a future rulemaking effort if necessary.

Mobile Entity Billing Requirements

In the final rule, CMS finalized their proposal that entities providing mobile diagnostic services must be enrolled in the Medicare program.

Revocation of Enrollment and Billing Privileges of IDTFs in the Medicare Program

CMS finalized the provision that require revoked physician organization, a physician, a non-physician practitioner, or an IDTF to submit all outstanding claims not previously submitted within 60 calendar days of the revocation effective date.

B. Conversion Factor and Budget Neutrality

Effective Jan. 1, 2009, the conversion factor (CF) for the MFS will be $36.066. This is a 5.3 percent decrease from the current 2008 CF of $38.08. Under MIPPA, it was mandated that there be a 1.1 percent increase in 2009.

C. Malpractice RVUs

In the final rule, CMS acknowledges that the issue of assigning MP RVUs for the TC of certain services continues to be a source of concern and reiterates that the agency will instruct its contractor to research available data sources for the MP costs associated with the TC portion of these codes and to determine what is included in general liability insurance versus PLI for physicians and other professional staff. If data sources are...
available, CMS plans to use the information as part of the update to the malpractice RVUs for CY 2010.

D. Geographic Practice Cost Indices (GPCI): Locality Discussion

There are 89 separate payment localities. For 2009, CMS did not propose to make any changes to the payment localities. CMS contracted with Acumen, LLC. They have a report titled, “Review of Alternative GPCI Payment Locality Structures,” which discusses four options that was described in the proposed rule. When CMS is ready to propose a change in the payment localities, it plans to provide opportunities for public comment before implementing any change.

Work GPCI
MIPPA extended the 1.000 work geographic practice cost index floor from July 1, 2008 to Dec. 31, 2009. There is a permanent 1.500 work GPCI floor in Alaska, beginning Jan. 1, 2009.

E. Portable X-Ray Issue

In the final rule, CMS finalized the provisions as proposed. CMS did not agree with the comment that suggested an alternative requirement for qualification as an x-ray technologist (e.g., ARRT) certification since ARRT certification is voluntary, and therefore, may not be required as a condition of employment.

F. Cardiac MRI

In the final rule, CMS determined that the existing NCD for MRI is applicable to the four cardiac MR codes because blood flow/velocity quantification is considered to be a component of these services, which according to the NCD is not considered reasonable and necessary, and therefore, is noncovered. CMS commented that any change in coverage would have to occur through the NCD process.

G. Potentially Misvalued Services under the Physician Fee Schedule

CMS has identified methods that they are requesting that the RUC to undertake to assist in identifying potentially misvalued codes to include 1) review of the fastest growing procedure codes; 2) review of Harvard valued codes; and 3) review of practice expense RVUs.

Updating High Cost Supplies
After careful review of information received on all supply items, CMS decided not to finalize the proposed process at this time and not to revise the prices for the supplies they needed price information. CMS comments that they plan to research the possibility of using an independent contractor to assist them in obtaining accurate pricing information. CMS will propose a revised process in future rulemaking.
**Review of Services Often Billed Together and the Possibility of Expanding the Multiple Procedure Payment Reduction (MPPR) to Additional Non-Surgical Procedures**

CMS plans to continue to work with the AMA RUC, MedPAC, and the specialty societies to determine whether there are additional services that should be either bundled or subjected to a MPPR.

**Requested Approaches for the RUC to Utilize**

In the final rule, CMS comments that MedPAC supports their plan to review the fastest growing procedure codes, services often provided together, and the Harvard valued codes. However MedPAC disagrees with the process of identifying misvalued services. They believe that it is the responsibility of CMS to identify potentially misvalued services and that CMS should establish a standing panel of experts to help identify overvalued services and to review AMA RUC recommendations. CMS takes no specific actions but indicates that they will continue to work with the AMA RUC, MedPAC, and the specialty societies on this issue. CMS acknowledges its proposed approaches are long term and that it will require time and effort from the AMA RUC and specialty societies to complete.

**AMA RUC Review of Potentially Misvalued Codes**

In the final rule, CMS comments that the AMA RUC started to review potentially misvalued codes using various screens, including codes with site of service and high intra-service work per unit time (IWPUT) anomalies and high volume and a new technology designation, during the 2008 AMA RUC meetings. Review of the identified clinical services revealed 204 codes. Of 204 codes identified for review, 48 were recommended for a reduction in valuation; 38 were recommended to maintain the same valuation; 105 were referred to CPT for further code clarification; and 13 were recommended for an increase in valuation. In the final rule, CMS acknowledges some problems with the AMA RUC methodology but agrees to accept the valuation for these codes for CY 2009 (other than the codes referred to CPT), including the conforming changes to the PE inputs for these codes, as applicable. The AMA RUC recommendations and CMS decisions are listed in Table 26 of the final rule.

**Table 26: AMA RUC Recommendations for Potentially Misvalued codes**

On the table, codes 47490, 71250, 71275, 72125, 72128, 73200, 73218, 73700, 76536, and 93976 are missing.

**H. Table 27: AMA RUC Recommendations and CMS’ Decisions for New and Revised 2009 CPT codes**

CMS accepted physician work RVUs for 4 new radiology and radiation oncology codes.

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>Work RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>77785</td>
<td>HDR BrachyTx, 1 Channel</td>
<td>1.42</td>
</tr>
<tr>
<td>77786</td>
<td>HDR BrachyTx, 2-12 Channel</td>
<td>3.25</td>
</tr>
<tr>
<td>77787</td>
<td>HDR BrachyTx, over 12 Channel</td>
<td>4.89</td>
</tr>
<tr>
<td>78808</td>
<td>IV Inj Ra Drug Dx Study</td>
<td>0.18</td>
</tr>
</tbody>
</table>
I. Multiple Procedure Payment Reduction for Diagnostic Imaging

CMS finalized their proposal to add the codes listed in Table 6.

TABLE 6: Procedures Proposed for Multiple Procedure Payment Reduction

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Short Descriptor</th>
<th>Code Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>70336</td>
<td>mri, temporomandibular joint(s)</td>
<td>Family 5 MRI and MRA (Head/Brain/Neck)</td>
</tr>
<tr>
<td>70554</td>
<td>Fmri brain by tech</td>
<td>Family 5 MRI and MRA (Head/Brain/Neck)</td>
</tr>
<tr>
<td>75557</td>
<td>Cardiac mri for morph</td>
<td>Family 4 MRI and MRA (Chest/Abd/Pelvis)</td>
</tr>
<tr>
<td>75559</td>
<td>Cardiac mri w/stress img</td>
<td>Family 4 MRI and MRA (Chest/Abd/Pelvis)</td>
</tr>
<tr>
<td>75561</td>
<td>Cardiac mri for morph w/dye</td>
<td>Family 4 MRI and MRA (Chest/Abd/Pelvis)</td>
</tr>
<tr>
<td>75563</td>
<td>Cardiac mri w/stress img &amp; dye</td>
<td>Family 4 MRI and MRA (Chest/Abd/Pelvis)</td>
</tr>
<tr>
<td>76776</td>
<td>Us exam k transpl w/doppler</td>
<td>Family 1 Ultrasound (Chest/Abdomen/Pelvis - Non-Obstetrical)</td>
</tr>
<tr>
<td>76870</td>
<td>Us exam, scrotum</td>
<td>Family 1 Ultrasound (Chest/Abdomen/Pelvis - Non-Obstetrical)</td>
</tr>
<tr>
<td>77058</td>
<td>Mri, one breast</td>
<td>Family 4 MRI and MRA (Chest/Abd/Pelvis)</td>
</tr>
<tr>
<td>77059</td>
<td>Mri, broth breasts</td>
<td>Family 4 MRI and MRA (Chest/Abd/Pelvis)</td>
</tr>
</tbody>
</table>

J. Other PE Direct Input Issues

Removal of Conscious Sedation (CS) PE Inputs for Services in Which CS is not Inherent- Technical Correction

CS PE inputs have been removed for the following codes:
22520: Percutaneous vertebroplasty thor
22521: Percutaneous vertebroplasty lumb
62268: Drain spinal cord cyst
62269: Needle biopsy, spinal cord

CMS is asking that the AMA RUC allow specialty societies to bring any codes forward to either the February or April 2009 RUC meetings if there is any other discrepancies between the CPT Addendum and the practice expense database is identified.

Contractor Pricing of CPT 77371 for Stereotactic Radiosurgery (SRS) Treatment Delivery

CMS received comments stating that the practice expense RVUs listed in Addendum B for this code is exceptionally inadequate. Commenters pointed out the difference in payments between those made under HOPPS and the MFS for code 77371. CMS plans to
ask the AMA RUC to review the direct practice expense inputs for this code. In the interim, CMS plans to contractor price code 77371 for 2009.

K. Application of the Health Professional Shortage Area (HPSA) Bonus Payment

There is an additional 10 percent bonus payment for physicians’ services provided in a year to a covered individual in an area that is designated as a geographic Health Professional Shortage Area (HPSA) as identified by the Secretary prior to the beginning of such year. The statute indicates that the HPSA bonus payment will be made for services provided during a year in areas that have been designated as HPSAs prior to the beginning of that year. As a result, the HPSA bonus payment is made for physicians’ services provided in an area designated as of December 31 of the prior year, even if the area’s HPSA designation is removed during the current year. However, for physicians’ services provided in areas that are designated as geographic HPSAs after the beginning of a year, the HPSA bonus payment is not made until the following year, if the area is still designated as of December 31 of that year.

In the CY 2009 PFS proposed rule, CMS proposed to clarify that physicians who provide services in areas that are designated as geographic HPSAs as of December 31 of the prior year but not included on the list of zip codes for automated HPSA bonus payments should use the AQ modifier to receive the HPSA bonus payment.

As a result of refinements in CMS systems, they expect that more areas that are eligible for the bonus payment will be on the list of zip codes eligible for automatic payment of the HPSA bonus, thereby reducing the number of physicians who need to use the modifier. CMS acknowledges that some physicians may not be aware of the need to use the modifier if they are furnishing services in a geographic HPSA that was designated after the list of eligible zip codes was created but prior to December 31.

CMS will continue to utilize their provider education resources to increase awareness of the appropriate application of the AQ modifier. CMS will also continue to refine their systems to include as many areas as possible to the list of zip codes that receive automatic HPSA bonus payments.

After careful consideration of all of the comments, CMS is adopting their proposal with minor revisions to clarify that physicians who provide services in areas that are designated as geographic HPSAs as of December 31 of the prior year but not included on the list of zip codes for automated HPSA bonus payments should use the AQ modifier to receive the HPSA bonus payment.

L. Physician and Nonphysician Practitioner (NPP) Enrollment Issues

Effective Date of Medicare Billing Privileges

CMS adopts the second approach. CMS finalized a provision that allows physicians, NPPs (including CRNAs), and physician or NPP organizations to retrospectively bill for services up to a 30 days prior to their effective date of billing when the physician or NPP
organization met all program requirements, including State licensure requirements, where services were provided at the enrolled practice location prior to the date of filing and circumstances precluded enrollment in advance of providing services to Medicare beneficiaries.

CMS also finalized a provision that allows physicians, NPPs, physician or NPP organizations to retrospectively bill for services up to a 90 days prior to their effective date of billing when the physician or NPP organization met all program requirements, including State licensure requirements, services were furnished at the enrolled practice location prior to the date of filing and a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act precluded enrollment in advance of providing services to Medicare beneficiaries.

**CMS also notes the following in the final rule:**

- CMS will be implementing a new Internet-based Provider Enrollment, Chain and Ownership System (PECOS), which CMS believes is more efficient than the traditional paper-application enrollment method, in three phases. In Phase I (expected to begin by the end of CY 2008), the Internet-based PECOS will be available for all individual physicians and NPPs. In Phase II (tentatively scheduled for implementation beginning in Spring 2009), the Internet-based PECOS will be available for all organizational providers and suppliers (except suppliers of durable medical equipment, prosthetics, orthotics and supplies, DMEPOS).

  - In Phase III (tentatively scheduled for implementation in CY 2010), the Internet-based PECOS would be available for DMEPOS suppliers. CMS emphasizes that all providers and suppliers will continue to have the option of submitting an enrollment application by paper. Moreover, physicians and NPPs choosing to use billing agents, clearinghouses, academic medical institutions, etc. will be required to submit a paper enrollment application to enroll or make a change in their Medicare enrollment record. Additional information regarding PECOS will be posted later this year on the Medicare provider/supplier enrollment Web site at www.cms.hhs.gov/MedicareProviderSupEnroll.

- The date of filing for an enrollment application submitted via the Internet-based PECOS will be the date the Medicare contractor receives both: (1) an electronic version of the enrollment application; and (2) a signature page containing an original signature that the Medicare contractor processes to approval.

- CMS expects that Medicare contractors will fully process most complete Internet-based PECOS enrollment applications within 30 to 45 calendar days compared to 60 to 90 calendar days in the current paper-based enrollment process. CMS says it will “consider” monitoring contractor performance with respect to the processing of enrollment applications by calculating the average length of time for initial enrollment applications, changes of information, and reassignments and making this information available to the public.
M. Physician Quality Reporting Initiative (PQRI)


2009 Measures
Two of the three new measures relevant to diagnostic radiology proposed were included in the final rule: “Inappropriate Use of BIRADS 3” and “Recording of Fluoroscopy Time for Procedures Using Fluoroscopy”. The two stroke imaging measures that have been in PQRI since 2007 were again included for 2009. It is not clear whether CMS will update specifications for the stroke measure, “Carotid Imaging Reporting” to reflect the revision that opens the measure to patient populations other than stroke patients.

CMS did not include the “CT Dose Reduction” measure that was listed in the MPFS proposed rule because the National Quality Forum declined to endorse the measure just prior to publishing of the Final Rule. CMS dropped this measure from the final list. Although one other radiology measure was endorsed by the NQF, “Reminder System for Mammograms,” CMS did not include this in proposed or final rules for 2009.

Seven measures that potentially may be reported by interventional radiologists that were in PQRI 2008 continue to be included in 2009 (four Perioperative Care measures, two Osteoporosis measures and one Critical Care measure). Newly included in 2009 is the first measure that nuclear medicine physicians can report, “Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy”. Three new measures were included in 2009 relevant to radiation oncology practices: “Plan of Care for Pain”, “Pain Intensity Quantified” and “Tissue Dose Constraints”. There are four other oncology/prostate cancer measures carried over to 2009 from previous years; however three previous oncology/prostate cancer measures were dropped from the 2009 list.

Reporting Options
In 2008, CMS implemented two alternative reporting options: alternative reporting periods and measure group reporting. CMS expanded on these reporting options for 2009 by adding four new measure groups. One of these new groups is Perioperative Care, reportable by many interventional radiologists (measures may apply to IRs who perform procedures such as kyphoplasty or vertebroplasty.

Measure Groups
A measure group is a subset of PQRI measures that have a particular clinical condition or aspect of care in common. Each measure group contains at least four PQRI measures and may be reported through claims-based or registry-based data submission. All measures within that group must be reported.
Alternative Reporting Periods
An alternative period is available when reporting measure groups. In place of reporting the full year, a provider can report for only six months by reporting 30 consecutive cases or an 80 percent patient sample from services provided from July 1 through December 31, 2009. The bonus payment for successful reporting of measure groups will be 2 percent of Medicare allowed charges for the six-month period.

Registry-Based Reporting
CMS has continued registry-based reporting as an additional method for PQRI participation in 2009. Registries must collect physician-submitted data and must be able to calculate at least three approved PQRI measures. The registry should provide for reporting of individual measures or measure groups.

Appeal Process
Comment was made on the proposed rule that CMS provide an appeal process for eligible professionals who participate but are not deemed to be successful; and should offer greater transparency in all aspects of the program including the provision of feedback. CMS’ response was that they have no authority to do establish an appeals process because the legislation authorizing/continuing PQRI does not provide for administrative or judicial review of (1) the determination of measures applicable to services furnished by eligible professionals; (2) the determination of satisfactory reporting; and (3) the determination of any incentive payment.

N. Physician self-referral
In the final rule, CMS did not take action on the notorious Stark in-office ancillary services exception because it did not offer any changes to the exception in the proposed rule. Thus, CMS deemed in-office-related comments “outside the scope of this rulemaking.” Fortunately, however, CMS reaffirmed that self-referral represents a fundamental problem (see pages 434-435 of Final Rule). The agency rebutted commenters’ claims that no evidence showed self-referral led to imaging overutilization. CMS countered that several studies establish such a link, including a recent GAO study that found overutilization of some in-office imaging. Notably, CMS indicated that it still is looking at “industry use” of the in-office exception and may offer changes in a future rulemaking.

The agency also made several changes in the radiology and radiation therapy categories of the Stark-covered “designated health services” (DHS) code lists (see pages 941-943). For instance, it deleted CPT® codes 78000, 78001, and 78003 from the ‘Radiology and Certain Other Imaging Services’ category. In CMS’s view, these thyroid-related codes do not involve imaging and thus should not be included in that category. Several high-intensity brachytherapy codes came off the radiation therapy DHS list. On the other hand, CMS added radiology codes 93306 (TTE w/ Doppler, complete) and A9580 (sodium fluoride F-18) to the list. It also added several radiation therapy codes such as HDR
brachytherapy treatment codes 77785, 77786 and 77787. CMS modified three Doppler-related codes to clarify that those only are Stark-covered DHS when used along with other codes.

O. Anti-markup provisions

General Overview
Historically, the anti-markup rule for diagnostic tests has prohibited physicians or suppliers profiting from, or marking up, the technical component (TC) of certain diagnostic tests that outside suppliers perform but which a different individual or entity bills to Medicare. The rule only applies to diagnostic tests that an office-based billing physician or supplier orders. Anti-markup limits generally do not apply to tests ordered for hospital inpatients or outpatients because non-physician owners such as hospitals do not order tests, as well as bill for them.

In the CY2009 final rule, CMS accepted some, but not all, of ACR’s recommendations. On balance, the final anti-markup regulations that will take effect January 1, 2009 are marginally better for radiology and quality patient care. CMS did take a modest step toward removing the profit motive for billing physicians who engage other physicians or suppliers to perform and interpret diagnostic tests. It refused to exempt from anti-markup diagnostic tests that are performed in space in a “centralized building” because that concept is too overbroad. CMS also declined to expand its “net charge” definition to allow practices to recoup overhead costs, which CMS recognized might incentivize higher utilization.

But by creating anti-markup exceptions around a shared practice model and relaxing the “site-of-service” parameters where tests occur, CMS has left open some disturbing loopholes that may be exploited. Another key problem is that CMS has created a supervision requirement that actually appears more onerous than the customary supervision requirements (general/direct/personal). ACR members who interpret studies off site from where they occur (e.g., via teleradiology) will be hard pressed to meet either new anti-markup exception. Teleradiologists likely will be unable to meet either the exception that mandates they provide at least 75 percent of their professional services through the ordering physician or group, or the exception which requires they perform their PC interpretation and supervise the TC “in the office of the billing physician or supplier.” Unless CMS has a last-minute change of position based on any comments it receives on the Final Rule, teleradiologists may well have to restructure their Medicare arrangements with clinicians and bill the PC separately.

Shared Practice versus Site of Service Approach
In the final rule, the agency decided that the anti-markup provisions will not apply to the TC or PC of a diagnostic test where the performing physician shares a practice with the billing physician or other supplier. To that end, it crafted two alternative paths or exemptions for physicians. “Alternative 1” centers on a “shared practice” approach. Under this model, a physician who is employed by or contracts – whether full-time or part-time – with a single physician or physician organization “shares a practice” with that
physician or organization. CMS wants physicians to analyze initially whether or not “Alternative 1” fits their arrangement(s) before considering Alternative 2. To qualify, the performing physician (who supervises the TC, performs the PC or both) must perform “substantially all” [at least 75 percent] of his or her professional services for the billing physician or other supplier. In that case, the services that the physician provides on behalf of the billing physician or other supplier will be exempt from anti-markup. For instance, a radiologist provides at least 75 percent of her interpretive services through a multispecialty group practice, and furnishes 25 percent of her professional services through two other physicians. Consequently, the radiologist would be deemed to “share a practice” with the group and thus avoid any anti-markup restriction.

“Alternative 2” uses CMS’s traditional site-of-service basis by applying the anti-markup payment restriction to non-purchased TCs and PCs that are performed outside the office of the billing physician or other supplier. If an employee or independent contractor physician conducts and supervises TCs, and performs PCs, in the office of the billing physician or other supplier, those services will fall outside the anti-markup zone. Any physician who does not meet the “substantially all” services requirement of “Alternative 1” should try to use the “Alternative 2” option. However, any radiologist who reads by teleradiology for a physician group will have a very difficult time supervising the TC on-site where the study occurs. Thus, the physician group likely will not be able to markup the PC and will have to bill only its net charge — or allow the teleradiologist to bill their PC separately.

CMS emphasized that, in either model, the billing physician or other supplier must exercise “sufficient control and a proper nexus” to the individuals who conduct and supervise a diagnostic study.

Locum Tenens Radiologists
In the final rule, the agency concluded that most locum tenens arrangements, and part-time and other on-call or similar arrangements, should be able to fit Alternative 1. The key will be for a locum tenens physician to furnish no more than 25 percent of his or her professional services as a locum tenens (or as a part-time physician for another billing group or moonlighting at a hospital). CMS disagreed with the ACR’s position that a locum or part-time physician for one specialty practice should be subject to anti-markup merely because they perform such work for a different specialty practice. Therefore, a radiologist may serve as locum tenens for one group practice for up to 25 percent of their total professional services, and provide same locums work for up to 25 percent for another group. Even if locum tenens physicians cannot satisfy Alternative 1, they have two other choices: attempt to meet Alternative 2’s site-of-service requirements or bill Medicare directly for their services.

For radiologists and radiology groups that hire locums tenens physicians, they can meet the anti-markup exemption as follows: a radiologist contracts with a group practice to render services in place of another radiologist, who is on vacation or otherwise away from the group. The second radiologist, who is the group’s regular employee, performs 100 percent of his professional services through the group. In CMS’ view, this
arrangement complies with Alternative 1 because the radiologist does at least 75 percent of his professional services via the group — thereby having a nexus with the group practice. CMS noted that it is irrelevant whether, or how frequently, the radiologist furnishes professional services to the group outside his locum-based arrangements.

**Defining the Office of the Billing Physician or Other Supplier**

In the final rule, CMS adopted its proposal to define “office of the billing physician or other supplier” more broadly. In its CY2008 final rule with comment period, CMS had defined it as “medical office space where the physician or other supplier regularly furnishes patient care.” However, many industry stakeholders protested that the rule failed to clarify whether certain types of space arrangements met that definition. CMS then delayed implementing most of the anti-markup rule until January 1, 2009 to further study the issue.

The agency in its CY2009 fee schedule NPRM proposed to clarify that this “office” represents space in which diagnostic testing services are performed, that is in the “same building” as where the ordering physician or other ordering supplier regularly furnishes care. The Stark rules define “same building” as a structure or combination of structures that share a single U.S. post office street address — for example, a medical office building that may be adjacent to an academic medical center. For physician organizations, the “office” would be the space in which the ordering physician performs substantially the full range of patient care services that the ordering physician provides generally.

CMS in the Final Rule adopted its proposal. It views the site-of-service approach, which uses the “same building” test, as “a reasonable means of determining whether a physician shares a practice and has a sufficient nexus with the billing physician or other supplier.”

Thus, suppose that a physician has office space on the first floor of a medical office building. He performs the full range of services he generally provides – so this space meets the anti-markup exception for “office of the billing physician or other supplier.” This physician orders a diagnostic test, that a technologist performs and that another physician supervises in a testing facility located in the building’s basement. This second physician also does the PC of the test in that facility. She reassigns her right to bill for the TC and PC of the test back to the first physician. The first physician and two other physicians share the diagnostic testing facility under a block-lease deal in which they all exclusively lease that space. Consequently, the final rule now exempts both the TC and PC from anti-markup restrictions because both occurred in the “office of the billing physician or other supplier.” Incidentally, that type of deal may happen more often because CMS still will permit block-lease deals as Stark-compliant.

Unfortunately, the agency declined to adopt ACR’s recommendation that anti-markup limits apply to different specialties who share the same building for diagnostic testing services. Shared space arrangements, in CMS’s view, appropriately balance promoting efficient care with safeguarding against overutilization or other abuse that may occur with “centralized” buildings for diagnostic studies.
CMS also added to Alternative 2 the requirement that, for the TC, the physician supervising the TC be an owner, employee or independent contractor of the billing physician or other supplier. Similarly, the physician who performs the PC must serve as an employee or independent contractor of the billing physician or other supplier.

**Reassignment Issues**

In the final rule, CMS decided not to finalize a definition of “outside supplier.” It deleted from the anti-markup provisions purchased tests and interpretations as separate bases for imposing an anti-markup limit. CMS concluded that having a purchased TC or PC as a stand-alone reason for banning anti-markup confused physicians and suppliers. It believes that Alternatives 1 and 2 are clearer and balance protecting legitimate, non-abusive arrangements and minimizing the risk of improper billing. CMS declined to create an exception for tests ordered by a physician in a physician organization that has no physician owners who might obtain profit shares. The agency concluded that its two alternatives essentially address its concern that Alternative 2 might impede nonprofit multispecialty groups that have campus-based treatment facilities (and therefore do not perform diagnostic testing in the “same building” where patients are seen). Most of these arrangements should meet either Alternative 1 or 2.

Nor did CMS change its definition of “net charge” or require direct billing in lieu of reassignment. Instead, CMS opted to impose restrictions on reassigning PCs by establishing the two alternative exceptions to anti-markup.

Notably, CMS rejected establishing specific requirements for physicians supervising the TC of diagnostic studies. Thus, CMS is not requiring that a physician who supervises the TC need be a radiologist. Rather, CMS referred to the current supervision levels that govern tests to which anti-markup should apply. This decision could undermine CMS’s stated intent of curbing inappropriate utilization of diagnostic testing because most practices likely will be able to meet the “shared practice” model. Additionally, CMS did not finalize IDTF standards for physician offices and thereby compel practices to meet the more rigorous IDTF criteria for a supervising physician. IDTF rules mandate proficiency in the tests that a physician supervises, which means practically that a radiologist serves as supervising physician at many IDTF sites.

With no IDTF safety net for physician offices that perform diagnostic tests, though, ACR believes that many practices simply will designate one of their own members as the general “supervising physician” for diagnostic studies. In that instance, TC billing will escape anti-markup if the billing physician can meet the “shared practice—substantially all” exception. On the PC side, independent contractor radiologists often interpret studies for multiple practices and thus likely will not meet the “substantially all/75 percent” threshold. In those instances, two options exist: ordering clinicians either will bill for the PC without markup or may allow the interpreting radiologist to bill separately for their PC services.
The ACR is currently reviewing the 2009 MFS final rule and will submit comments to CMS. We will keep the membership updated on any further changes. Please contact the Economics and Health Policy Department at 800-227-5463, ext. 4584 with any questions.

[Click here](#) to read the 2009 MFS final rule in its entirety.