MEDICARE ANTI-MARKUP RULES

What Medicare used to call "purchased service rules", they now refer to "anti-markup rules" and this deals with diagnostic tests that have either the technical or professional portion of the test performed by another physician or provider. ‘

Typically, when a physician bills Medicare for a diagnostic test, the physician does not apply a TC or 26 modifier as they are doing both sides of it (technical and professional interp). Occasionally, a doctor will need to split the test and bill for only one portion. For instance, a general practitioner performing an EKG in the office might use a 93005 on the EKG to indicate they did the technical portion when they send the test out to a cardiologist to do the interp, instead of billing 93000. The same thing might apply with an x-ray being billed with a TC modifier when they send the image out to a radiologist or orthopedist for the interpretation.

There is a problem when the doctor buys a machine in to do a test on the patient and they want to charge the doctor money to have an interpretation provided to the doctor by another doctor. That is a purchased service that falls within the anti-markup rules (in our opinion). I was recently asked about a service that wants to charge $300 to the primary care physician for an interpretation by a Neurologist, while they encourage the primary care physician to bill Medicare for the entire cognitive testing. They want the doctor to bill Medicare $500 for the entire test and pay their company $300 for the interpretation. Most doctors are not aware that this claim to Medicare would have to be split into two charges: One for the technical component and one showing that the interpretation is a purchased service. If not careful the doctor may pay more for a service than they receive in reimbursement! Let's break it down:

Doctor bills 95957 TC to Medicare: MPFS = $176.07 Medicare pays 80%
Doctor bills 95997 26 - purchased: MPFS = $101.35 The allowed is the lowest of:

1. The physician's charge amount on the claim,
2. The Medicare Physician Fee Schedule,
3. The net amount the physician paid the supplier (amount paid for the interp)

So - if the doctor pays $100.00 to a company for the interp, that $100 becomes the allowed amount for the interpretation and Medicare pays 80% of that or $80.00. If the patient has Medicaid as secondary or is unable to collect the 20% from the patient or secondary insurance - the doc just paid $20 more to the company than received. The doctor is required to denote on the claim that part of the test was purchased in block 20 on the claim form also means that purchased service is the only item on that CMS 1500 claim form, as you're not allowed to have a purchased component of a test on the same claim form as a non purchased component.

Be careful folks. Folks selling some neuroscience testing may not tell you everything you need to know. You don't want to pay them $300 today and 2 years from now you get audited and wonder where they went when you're paying Medicare back tens of thousands.