CMS may take aim at interpretation services

Look back at convoluted history of self-referral regulation offers insights into future rules

--Thomas W. Greeson, J.D.

Diagnostic imaging rests squarely within the sights of regulators, so don't be surprised if significant rule changes relating to imaging services may be in the offing. One likely target relates to how interpretation services, including those provided via teleradiology, can be performed and billed. I predict that the Centers for Medicare and Medicaid Services may for the first time propose regulations to take the profit out of many interpretation arrangements.

In its proposed rules for the 2007 Medicare Physician Fee Schedule, CMS signaled its intention to tackle potentially abusive diagnostic testing services arrangements, including those involving interpretation services. Some of the ideas the agency has floated for changing Medicare's reassignment rules could have a big impact on the market for interpretation services.

Some background on the reassignment rules can help predict where the rules may be headed. Shortly after establishing the Medicare program in the 1960s, Congress restricted payment for Medicare services to the beneficiary or to the party that furnished the services and accepted assignment of the beneficiary's claims. Some exceptions were created at the time. One permitted an independent contractor physician to reassign Medicare Part B payments to clinics and physician groups. This exception allowed nonemployee radiologists to contract and read studies performed in other physician offices that would pay those radiologists for their services and bill globally. It was available, however, only if the services were...
performed on the premises of the physician practice billing for the interpretations. Thus, for reassignment purposes, an independent contractor radiologist who provided interpretation services for a group practice had to perform those services at the group practice's site.

The Medicare Moderation Act of 2003 (MMA) liberalized the reassignment rules to remove this "on the premises" requirement for reassigned claims. As a result, independent contractor physicians were permitted to reassign their rights to receive Medicare Part B payments to not only a clinic or physician group but also an independent diagnostic testing facility (IDTF) or any other billing entity and to do so regardless of where they actually furnished the services.

Although the MMA relaxed the Medicare reassignment rules, the Stark anti-self-referral law remained in play. As regular Diagnostic Imaging readers know, Stark prohibits a physician from referring a Medicare patient for the provision of "designated health services," including either the technical or professional component of diagnostic radiology services or both, to an entity in which the physician has a financial interest.

Professional interpretation services for a Medicare or Medicaid patient referred by an owner of a group practice to his or her own group practice triggers Stark. There is a physician services exception. This exception requires that any physician performing the professional services as an independent contractor must perform them "in the group practice's facilities," or, in the view of CMS, onsite. Sound familiar?

Consequently, even though the MMA expanded the scope of the reassignment rule to permit professional services to be performed offsite, if a group practice contracts with a local radiology group—or even a teleradiology company— to perform professional interpretations of diagnostic tests that the group practice will bill for globally, the radiologists must perform the interpretations onsite at the group practice's facility. Otherwise, these interpretation services must be billed separately by the contracting radiologists.

POSSIBLE NEW RULEMAKING

Prior to the MMA revisions, the only way a physician practice or other supplier of a diagnostic test could bill for professional interpretations performed by an independent contractor offsite was through the purchased interpretation rule. Under this rule the diagnostic testing supplier can submit a claim for the professional component of a diagnostic test performed offsite by an independent contractor physician only if all of the following requirements are met:

- The independent contractor is enrolled in the Medicare program.
- The diagnostic test was ordered by a physician or medical group that is independent of both the person or entity that performed the technical component and the physician or medical group that performed the interpretation.
- The independent contractor performing the interpretation does not see the patient.
- The entity that bills for the professional interpretation performs the technical
component of the diagnostic test.

It is primarily because of the second point above that the purchased interpretation rule can be used only by an IDTF or an office practice of a radiology group. In most cases, a self-referring orthopedic, cardiology, or other group practice that owns diagnostic imaging equipment to which its physicians refer their patients cannot purchase interpretation under the criteria above, since the group practice would be both ordering and performing the technical component for its own patients.

In 2006, CMS announced that it was considering applying all of the requirements of the purchased interpretation rule to any arrangement between a physician or medical group and another physician or medical group to perform interpretations of diagnostic tests pursuant to a reassignment. If adopted, this proposal could be problematic for two types of arrangements: hospital-based radiology groups that use independent contractors for official reads via teleradiology, and nonradiology physician practices that wish to contract for professional interpretation services and bill for those services on a global basis.

When applied to self-referring medical groups, this approach could significantly impair the ability of referring physician practices to bill globally for interpretations performed pursuant to a reassignment. Amending reassignment rules to require that the entity that performs the test and bills for the professional component must be independent from the physician/entity that ordered the test would effectively bar a referring physician from performing and billing for imaging services by using the in-office ancillary services exception to Stark. Not a bad outcome.

Such a change to the reassignment rule could, however, also impair non abusive arrangements between hospital-based radiology groups and teleradiology companies. In an era of growing need for subspecialty reads and 24/7 coverage, it is becoming more common for a hospital-based radiology group to bill Medicare for the professional component services under the local radiology group's number pursuant to an official read agreement with a teleradiology company. Carrier jurisdiction rules now in place also make such arrangements difficult but not impossible. If CMS were to change the rule as proposed, however, the hospital-based group would be precluded from billing Medicare for the interpretations performed by the teleradiology service, since the hospital-based group would not satisfy the requirement that the group perform and bill for the technical component of the service under its supplier number.

Thus, while this approach could be an effective barrier to self-referral, my guess is that CMS would likely take a less restrictive step to try to curtail abuse caused by self-referral, while at the same time actually tearing down existing barriers to such arrangements.

**ANTI-MARKUP RULE**

What CMS is likely to do, in my opinion, is adopt requirements for reassigned interpretation services by contractors that are akin to Medicare's purchased diagnostic test rule. This rule provides that if the technical component of a diagnostic radiology procedure was not supervised by the physician who is billing
for the service or by another physician in the practice, then Medicare will pay only the lower of the costs charged by the supplier who performed the test for the billing physician or the Medicare fee schedule amount. In other words, the physician billing for a purchased test cannot mark up the charge (that is, take a profit) on the technical component of the test above what he or she paid to the entity that actually performed the test.

CMS appears to be leaning toward a similar anti-markup prohibition for interpretation services billed by physician group practices when the interpretation was performed by an independent contractor physician not onsite at the physician practice's facilities. If the referring physician's own practice contracts with and pays a contractor radiology group $200 to read an MRI study of the brain, for example, and the contractor read it remotely from the referring physician's practice, CMS could treat the arrangement as a purchased interpretation. As such, the referring physician's group could bill for the interpretation service but would be prohibited from marking it up and billing Medicare any more than the contractor's $200 charge for the professional component.

At the same time, CMS should—one would hope—also amend Stark to remove the onsite requirement so long as there is no markup. CMS should also take steps to eliminate the agency's arcane jurisdiction requirements as to which state Medicare carriers or contractors can be billed. If CMS were to adopt the reporting system currently in place for IDTFs that identifies the zipcode location of the interpreting physician, another regulatory barrier to teleradiology will have been taken away. Eliminating both the Stark and carrier jurisdiction barriers could help teleradiology services proliferate.

CMS finalized its 2007 Medicare Physician Fee Schedule rules without adopting any of the changes it had considered regarding interpretation services and reassignment. But CMS is even more likely to move this year to halt the growth of in-office imaging caused by self-referring physicians by revising the important, but often overlooked, regulatory requirements for the reassignment of the right to bill professional component radiology services. My money is on a new anti-markup rule as the best overall approach.

Mr. Greeson is a partner in the healthcare group of Reed Smith LLP in Falls Church, VA. He can be reached at 703/641-4242 or tgreeson@reedsmith.com