Medicare
Carriers Manual
Part 3 – Claims Process

Department of Health and Human Services (DHHS)
Centers for Medicare & Medicaid Services

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CHANGE REQUEST 1815

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
15048 – 15048 (Cont.)	15-45 - 15-45.1 (2 pp.)	15-45 – 15-45.1 (2 pp.)

CLARIFICATION--EFFECTIVE DATE: Not applicable
IMPLEMENTATION DATE: October 1, 2001

Section 15047, Preoperative Services Paid Under the Physician Fee Schedule, this instruction provides **further clarification** to payment policy for preoperative evaluations obtained outside of the global surgical period, and establishes a clear hierarchy for denying such services.

Services identified with ICD-9 code V72.81 through V72.84 are not considered routine services and may not be denied, by carriers, as routine services. However, these ICD-9 codes do not, in and of themselves, establish medical necessity, therefore claims containing these codes may be subject to medical necessity determinations as described in §15047 H.

These instructions should be implemented within your current operating budget.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

F. Applicability of §1862(a)(7) of the Act to Preoperative Services.--

1. Preoperative Examinations.--For purposes of billing under the Physician Fee Schedule, medical preoperative examinations performed by, or at the request of, the attending surgeon does not fall within the statutory exclusion articulated in §1862(a)(7) of the Act. These examinations are payable if they are medically necessary (i.e., based on a determination of medical necessity under §1862(a)(1)(A) of the Act) and meet the documentation requirements of the service billed. Determination of the appropriate E/M code is based on the requirements of the specific type and level of visit or consultation the physician submits on his claim (e.g., established patient, new patient, consultation).

2. Preoperative Diagnostic Tests.--When billing under the Physician Fee Schedule, preoperative diagnostic tests performed by, or at the request of, the physician performing preoperative examinations, do not fall within the statutory exclusion articulated in §1862(a)(7) of the Act. These diagnostic tests are payable if they are medically necessary (i.e., they may be denied under §1862(a)(1)(A)).

G. ICD Coding Requirements for Preoperative Services.--All claims for preoperative medical examination and preoperative diagnostic tests (i.e., preoperative medical evaluations) must be accompanied by the appropriate ICD-9 code for preoperative examination (e.g., V72.81 through V72.84). Additional appropriate ICD-9 codes for the condition(s) that prompted surgery and for conditions that prompted the preoperative medical evaluation (if any), should also be documented on the claim. Other diagnoses and conditions affecting the patient may also be documented on the claim, if appropriate. The ICD-9 code that appears in the line item of a preoperative examination or diagnostic test must be the code for the appropriate preoperative examination (e.g., V72.81 through V72.84).

H. Reasonable and Necessary Services.-- For the purpose of establishing preoperative services as reasonable and necessary, all claims are subject to applicable national coverage decisions. In the absence of a national coverage decision, reasonable and necessary services are determined by carrier discretion. Establishing reasonable and necessary preoperative medical evaluations is facilitated when the ICD-9 codes(s) for the condition(s) that prompted surgery, and for the conditions that prompted the preoperative medical evaluation (if any), are documented as additional diagnoses on the claim.

15048. PURCHASED DIAGNOSTIC TESTS

A. General.--Section 1842(n) of the Act establishes payment rules for diagnostic tests billed by a physician but performed by an outside supplier. For this purpose, diagnostic tests are tests covered under §1861(s)(3) of the Act other than clinical diagnostic laboratory tests. These include, but are not limited to, such tests as X-rays, EKGs, EEGs, cardiac monitoring, ultrasound, and the technical component of physician pathology services furnished on or after January 1, 1994. Physician pathology services are the services described in §§15022.B and C. (Note that screening mammography services are covered under another provision of the Act and are not subject to the purchased services limitation.) These rules apply to the test itself (the TC) and not to physicians' services associated with the test.

B. Payment.--If a test is personally performed by a physician or is supervised by a physician, such physician may bill under the normal physician fee schedule rules. This includes situations in which the test is performed or supervised by another physician with whom the billing physician shares a practice. For this purpose, services under a physician's supervision has the same meaning as is required for services to be considered incident to a physician's service (see §2050.1), i.e., direct supervision of the physician's own employees or of his or her medical group which constitutes a physician directed clinic under §2050.3. The supervision requirement is not met when the test is administered by supplier personnel regardless of whether the test is performed at the physician's office or at another location. In addition, for the supervision requirement to be met, the personnel

must be employed by the physician or by his or her medical group in his, her, or its medical practice. The fact that a physician may have an ownership interest in the outside supplier is not material to this determination, and employees of such supplier are not considered the physician's employees for purposes of this provision

If a physician bills for a diagnostic test performed by an outside supplier, the fee schedule amount for the purchased service equals the lower of the billing physician's fee schedule or the price he or she paid for the service. The lower figure is the fee schedule amount for purposes of the limiting charge. (See §17002.) The billing physician must identify the supplier (including the supplier's provider number) and the amount the supplier charged the billing physician (net of any discounts). A physician who accepts assignment is permitted to bill and collect from the beneficiary only the applicable deductible and coinsurance for the purchased test. A physician who does not accept assignment is permitted to bill and collect from the beneficiary only the fee schedule amount (as defined above) for the purchased test. The limiting charge provision is not applicable.

If the physician does not identify the supplier and provide the other required information, no payment is allowed, and the physician may not bill the beneficiary any amount for the test.

C. Sanctions.--Physicians who knowingly and willfully, in repeated cases, bill Medicare beneficiaries amounts beyond those outlined in §15048.B are subject to the penalties contained under §1842(j)(2) of the Act.

D. Questionable Business Arrangements.--Section 15048.B imposes no special charge or payment constraints on tests performed by a physician or a physician's employees under his or her supervision. However, attempts may be made by the medical diagnostic community to adjust or establish arrangements which continue to allow physicians to profit from other's work or by creating the appearance that the physician has performed or supervised his/her employees' performance of the service. Some of these arrangements may involve cardiac scanning services and mobile ultrasound companies leasing their equipment to physicians for the day the equipment is used and hiring out their staff to the physicians to meet the supervision requirement.

The bonafides of these arrangements are extremely suspect. CMS views this arrangement as a transparent attempt to circumvent the prohibition against the mark-up on purchased diagnostic tests. The mere issuance of a W-2 from the physician does not automatically make the leasing company's technician the physician's employee for purposes of our employer-employee test. Rather, the determination as to a valid employer-employee relationship is dependent upon factors such as who has the right to hire and fire, who trains the employee, who is paying health and retirement benefits, who schedules work, who approves sick and vacation time, and so forth. If you have any doubt that a particular arrangement is a valid employer-employee relationship and/or believe that a physician is billing for a purchased diagnostic test in excess of the amount permitted, refer the case to the Office of the Inspector General (OIG) for investigation as a potential violation of §1842(n) of the Act.

Another arrangement to circumvent the purchased diagnostic service provision is for the ordering physician to reassign his/her payment for the interpretation of the test to the supplier. The supplier, in turn, bills for both the test and the interpretation and pays the ordering physician a fee for the interpretation. This arrangement violates §1842(b)(6) of the Act, which prohibits Medicare from paying benefits due the person that furnished the service to any other person, subject to limited exceptions discussed in §3060.D. Also, this arrangement could constitute a violation of §1128 B (b) of the Act, which prohibits remuneration for referrals (i.e., kickbacks).

Violations of §1128B (b) of the Act may subject the physician or supplier to criminal penalties or exclusion from the Medicare and Medicaid programs. Illegal remuneration for referrals can be found even when the ordering physician performs some service for the remuneration.