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2008 PHYSICIAN FEE SCHEDULE MAY CHANGE THE WAY PHYSICIANS ORDER DIAGNOSTIC TESTS

The recently published 2008 Physician Fee Schedule Rule (Final Rule) will have far-reaching implications in the way physicians provide diagnostic testing.

The final rule permits physicians to purchase and bill for diagnostic tests, but does not permit them to profit from such tests. The final rule addresses CMS' concern regarding diagnostic services provided in "centralized buildings" and those where physician groups purchase or contract for the provision of diagnostic tests. The basis for concern is the potential for a physician to realize a profit on the tests, which might then lead to overutilization resulting in higher costs to the Medicare program.

The final rule imposes an anti-markup provision on the technical component (TC) and professional component (PC) of diagnostic tests that are ordered by a billing physician or other supplier if the TC or PC is purchased from an "outside supplier" or if it is performed at a site other than the office of the billing physician or other supplier.

Under the anti-markup provisions, the amount at which a physician practice may bill Medicare for diagnostic tests may not exceed the lowest of the following amounts:

- 1) The performing supplier's net charge to the billing physician or other supplier.
- 2) The billing physician or other supplier's actual charge.
- 3) The fee schedule amount for the test that would be allowed if the performing supplier billed directly.

CMS creates a new definition for an "office of the billing physician or supplier" without any reference to the definition of "same building" in the Stark law in-office ancillary services exception. The office of the billing physician or supplier is defined as the "medical office space where the physician or other supplier regularly furnishes patient care." If the billing physician or other supplier is a physician organization, the "office of the billing physician or supplier" is defined as the space in which the physician organization provides "substantially the full range of patient care services that the physician organization provides generally."

The rule is effective January 1, 2008.

Physician Fee Schedule Conflict With Stark In-Office Ancillary Services Exception

The anti-markup provisions in the 2008 Physician Fee Schedule Rule (Final Rule) are separate and distinct from the Stark anti-referral law (Stark Law).

Historically, practices looked to the Stark Law in-office ancillary services exception when structuring the provision of diagnostic testing. For example, a radiology group with its offices on the second floor of a medical office building may have located its MRI machine on the first floor of the building in compliance with Stark Law "same building" criteria.

Under the Final Rule, any MRI test would be subject to the anti-markup provision because the MRI is not located in the office where the physician practice provides substantially the full range of services.

In conclusion, diagnostic tests not performed in a physician practice's office space may no longer be economically feasible. If a physician group complied with the Stark in-office ancillary services exception and located an MRI on a different floor of the same building where the practice office is located, the practice will not be able to include any costs related to the MRI equipment in its net charge to Medicare for the technical component.

*Delay until 1/1/09
TC of a purchased
diagnostic test - pathology
in "centralized bldg"
that does not qualify
as "same building"*

REGULATORY UPDATE

CMS REPORTS MEDICARE SPENDING GROWS 18.7% IN 2006 TO \$2.1 TRILLION

The Center for Medicare and Medicaid Services (CMS) reports that spending for the Medicare program grew 18.7% in 2006, double the 9.3% growth rate in 2005.

The CMS report found that total healthcare spending in the U.S. reached \$2.1 trillion in 2006, or \$7,026 per person (compared to \$6,649 per person in 2005). Health spending accounted for 16% of the nation's gross domestic product in 2006.

CMS cites that half the growth resulted from spending on Medicare Part D prescription drug coverage. The Part D benefit also had the effect of shifting spending from Medicaid to Medicare with the transfer of dual-eligible individuals to the Part D benefit. CMS found that Medicare's share of healthcare spending increased from 29% in 2005 to 34% in 2006, while Medicaid spending declined 5% from 45% in 2005 to 40% in 2006.

A 25% increase in Medicare Advantage program enrollment, resulted in Medicare Advantage spending as a share of total Medicare spending increasing to 18% in 2006, up from 14% in 2005.

Spending growth fell with respect to a number of healthcare providers. Hospital spending growth was down 0.3 percentage points from 2005 to 7% in 2006. Spending growth for physician and clinical services at 5.9% was the slowest rate of growth since 1999. In addition, spending growth for nursing homes slowed

from 4.9% in 2005 to 2.5% in 2006. At the same time, spending growth for home healthcare services decreased from 12.3% in 2005 to 9.9% in 2006.

The CMS report can be found in the online journal *Health Affairs*.

OIG REPORTS \$43 BILLION IN 2007 SAVINGS AND RECOVERIES

The Department of Health and Human Services Office of Inspector General (OIG) reported a record \$43 billion in fiscal year 2007 savings and recoveries.

The OIG's report notes that its \$43.08 billion in savings accounts for \$39 billion in implemented recommendations and other actions to put funds to better use; \$1.9 billion in audit receivables (up from \$789 million in 2006); and \$2.18 billion in investigative receivables (up from \$578 million in 2007).

OIG reported exclusions of 3,308 individuals and entities for engaging in fraud or abuse with respect to federal healthcare programs and/or their beneficiaries; 447 criminal actions; and 262 civil actions.

OIG highlighted some of its biggest compliance accomplishments in 2007, including a \$635 million settlement with the Purdue Frederick Company, Inc. and Purdue Pharma, L.P.



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