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Revision to CMS Manual Related to Anatomic Pathology Raises Additional Global Billing Issues [Ober|Kaler]

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The Centers for Medicare & Medicaid Services (CMS) recently amended Medicare Claims Processing Manual (MCPM) provisions related to payment for anatomic pathology services [PDF] to specifically address submission of such claims on a global basis.

While these changes may have clarified application of global billing principles to anatomic pathology, they may have contributed to the continuing uncertainty regarding global billing requirements generally.

Global Billing for Diagnostic Services

Principles governing global billing for diagnostic services such as radiology and anatomic pathology have been misunderstood frequently. This may result, in part, from the lack of a universally known and accepted definition of the term. In the strict sense, a global bill includes a claim for payment for a single service that reflects both its technical component (TC) and professional component (PC). Global billing does not occur when the billing entity submits separate paper claims for the TC and PC of a diagnostic service on a CMS-1500 form; nor is a single electronic claim, with separate line item charges for the TC and PC, considered a global bill.

Total Medicare payments should be the same whether a diagnostic service is billed globally or separate claims for its TC and PC are submitted (although in a recently filed *qui tam* action against a clinical laboratory, it was alleged that the laboratory's practice of billing separate TC and PC charges constituted "unbundling" resulting in overbilling Medicare). The advantage of global billing is potential convenience for both the billing entity and the patient who will receive one bill or explanation of benefit (EOB) for what he or she perceives as a single diagnostic service, rather than separate bills or EOBs for the service's TC and PC. Additionally, when submitted to a private insurer, a global bill may prevent the patient from being responsible for separate copayments for the TC and PC. For this reason, entities that are able to bill on a global basis may have a significant marketing advantage over those that are required to bill for the TC and PC separately.

The disadvantage of a global bill is that such a claim is not literally accurate unless precisely the same information applies to both the TC and PC. Similarly, a global bill may not include all of the information required to determine the proper payment amount, particularly as to the Medicare payment locality in which each particular test component was performed. Therefore, in some cases, a global bill could prevent the Medicare contractor from making correct payment determinations. For that reason, global bills are not permissible when either the TC or PC is subject to Medicare anti-markup limitations; a global bill that does not include a separate payment claim for each service component would not allow the Medicare contractor to determine the proper payment for the TC or PC subject to the payment limitations. See MCPM, Ch. 1, General Billing Requirements, § 30.2.9.

Radiology and Other Diagnostic Procedures

The MCPM states that radiology services and other diagnostic procedures can be billed on a global basis "when the TC and the physician who provides the PC… are furnished by the same physician or supplier entity and the PC and TC components are furnished within the same Medicare physician fee schedule payment locality." MCPM, Ch. 13, Radiology Services and Other Diagnostic Procedures, § 150(D). The provision indicates that the mere fact that the TC and PC have the same place of service (POS) code – which reflects the setting in which the service was performed, rather than the specific location – does not permit the procedure to be billed globally. In a related FAQ issued on April 25, 2013, CMS clarified that in order for a global diagnostic service code to be billed, the same physician or supplier entity must furnish both the TC and PC, and they must have been furnished within the same Medicare physician fee schedule (MPFS) payment locality www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQs-CR7631-4-25-13.pdf. According to CMS, "[t]he TC and PC may be furnished in different locations as long as they are furnished within the same MPFS payment locality."

Pathology Services

As a result of the recent issuance of CMS Transmittal 2714, CR 8013 (May 24, 2013), the MCPM states that global billing of pathology services is permissible only "when the PC and TC are furnished by the same physician or supplier entity." MCPM, Ch. 12, Physicians/Non-Physician Practitioners, § 60(D). This is consistent with the radiology provision. But the revised MCPM provision goes on to state: "For example, where the PC and the TC… are provided in the same service location, this is reflected as the address entered into Item 32 on CMS Form 1500, which provides the ZIP Code to pay the right locality/GPCI." CMS states that "[i]n this case, the physician/entity may bill globally." By contrast, according to CMS, "if the PC and the TC are each provided in different service locations (enrolled practice locations), the PC and the TC must be separately billed."

Thus, it appears that, in addition to being furnished by the same entity and in the same Medicare payment locality as provided for in the radiology provisions, the TC and PC of a pathology service must be performed at the same location in order to be billed globally. This requirement would appear unnecessary. After all, what difference should it make that the pathologist performed the interpretation across the street from the facility in which the slide was prepared (unless the road served as the border for two Medicare payment localities)? However, CMS has indicated that, in that scenario, separate claims for the TC and PC of the service are required, even if the pathologist interpreting the slide and the laboratory technician who prepared it were employed by the same entity.

Questions Remaining

The provision addressing the circumstances under which radiology services may be billed on a global basis does not include references to "service location," "address," or "enrolled practice location." As a result, radiology services are not subject to the "same location" requirement as are pathology services. But why are the requirements for billing pathology services globally more stringent than those that apply to radiology? Hopefully, CMS will address this issue in the future. Meanwhile, I keep thinking of the camel – the horse designed by committee – and wonder whether too many people have been involved in preparing these Medicare instructions.