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Information for Medicare Fee-For-Service Health Care Professionals

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MMA - Independent Laboratory Billing for the Technical Component (TC) of Physician Pathology Services to Hospital Patients

Note: This article was updated on April 6, 2013, to reflect current Web addresses. This article was previously revised on July 30, 2007, to show that important new information on this issue is available in *MLN Matters* article MM5468 (<http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM5468.pdf>). In essence, according to MM5468, qualifying independent laboratories may continue to bill Medicare for the TC of physician pathology services furnished to Medicare patients of a covered hospital stay during calendar year 2007. Be sure to view MM5468 for details.

Provider Types Affected

Independent laboratories

Provider Action Needed

This instruction implements section 732 of the Medicare Modernization Act (MMA) that extends the provision of Section 542 of Benefits Improvement Protection Act of 2000 (BIPA) for services furnished in 2005 and 2006. Section 542 of BIPA allows the carrier to continue to pay independent laboratories under the physician fee schedule for the technical component of physician pathology services furnished to patients of a covered hospital.

Background

In the final physician fee schedule rule published in the Federal Register on November 2, 1999, the Centers for Medicare & Medicaid Services (CMS) stated that it would implement a policy to pay only hospitals for the Technical Component (TC) of physician pathology services furnished to hospital inpatients. Prior to this proposal, any independent laboratory could bill the carrier under the physician fee schedule for the TC of physician pathology services provided for a hospital inpatient.

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The regulation provided that (for services furnished on or after January 1, 2001) a carrier would no longer pay claims to the independent laboratory under the physician fee schedule for the TC of physician pathology services for hospital inpatients. Similar treatment was provided under the outpatient prospective payment system for the TC of physician pathology services to hospital outpatients. This change was to take effect for services furnished on or after January 1, 2001. The delay was intended to allow independent laboratories and hospitals sufficient time to negotiate arrangements.

However, Section 542 of BIPA provided that Medicare carriers could continue to pay for the TC of physician pathology services when an independent laboratory furnishes this service to an inpatient or outpatient of a covered hospital. The BIPA-542 provision applied only to services furnished during 2001 and 2002.

For this provision, covered hospital means a hospital that had an arrangement with an independent laboratory that was in effect as of July 22, 1999, under which the laboratory furnished the TC of physician pathology services to fee-for-service Medicare beneficiaries who were hospital inpatients or outpatients, and the laboratory submitted claims for payment for the TC service to a carrier. The TC could have been submitted separately or combined with the professional component and reported as a combined service.

Section 732 of the MMA extends the BIPA-542 provision for services furnished during 2005 and 2006. Your carrier will require independent laboratories that had an arrangement on or prior to July 22, 1999 with a covered hospital to bill for these services to provide a copy of this agreement or other documentation substantiating that an arrangement was in effect between the hospital and independent laboratory as of that date.

However, note that carriers will return claims for the TC of physician pathology services as unprocessable when submitted by those independent laboratories that did not have an arrangement established with a covered hospital on or prior to July 22, 1999, to bill for these services under the Medicare Physician Fee Schedule.

Additional Information

The *Medicare Claims Processing Manual* (Pub. 100-04), Chapter 12 (Physician/Practitioner Billing) has been revised to reflect the changes in this CR.

The updated manual instructions are attached to the official instruction released to your carrier. You may view that instruction by going to

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R382CP.pdf> on the CMS website.

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If you have any questions, please contact your carrier at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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