CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1276	**Date: August 9, 2013**
	Change Request 8399

SUBJECT: Revision to the CWF Edit for Technical Component (TC) of Pathology Services Occurring on the Same Day as an Outpatient Hospital Visit

I. SUMMARY OF CHANGES: This CR will refine the CWF edit implemented under CR 5347 to reduce the number of "false positives" that improperly deny claims for the technical component (TC) of physician pathology services furnished to a hospital outpatient when the DOS on the TC of pathology claim is the same as the DOS on an outpatient hospital claim.

EFFECTIVE DATE: January 1, 2014
IMPLEMENTATION DATE: January 6, 2014

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
One-Time-Notification
**Unless otherwise specified, the effective date is the date of service.*

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 1276	Date: August 9, 2013	Change Request: 8399

SUBJECT: Revision to the CWF Edit for Technical Component (TC) of Pathology Services Occurring on the Same Day as an Outpatient Hospital Visit

EFFECTIVE DATE: January 1, 2014
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I. GENERAL INFORMATION

A. Background: Change Request (CR) 5347 (Transmittal 1221, issued on April 18, 2007) implemented a process to prevent payments for the technical component (TC) of radiology and pathology services furnished to an inpatient or outpatient of a hospital by any entity other than the admitting hospital. At the request of the industry to allow independent laboratories and hospitals sufficient time to negotiate arrangements, provisions established under Section 542 of the Benefits Improvement and Protection Act of 2000 (BIPA), administrative extensions of these provisions, and provisions established under subsequent legislative extensions, delayed the implementation of the policy change until July 1, 2012. Therefore, for dates of service from January 1, 2007 through June 30, 2012, Medicare continued to pay independent laboratories (IL) and pathologists for the TC of physician pathology services when furnished to an inpatient or outpatient of a covered hospital. (Covered hospital refers to a hospital that had an arrangement with an independent laboratory that was in effect as of July 22, 1999, under which a laboratory furnished the TC of physician pathology services to fee-for-service Medicare beneficiaries who were patients of a hospital and submitted claims for payment for the TC to a carrier.)

As a result of CR 5347, Common Working File (CWF) edit 729F was created to prevent payment of the TC of pathology services when an outpatient hospital service occurs on the same date of service (DOS). This edit (among others) was activated for dates of service beginning July 1, 2012 due to the expiration of all legislative extensions of the moratorium on implementation of the regulation at 42 CFR § 415.130 (d), which provides that the TC of physician pathology services provided to a hospital inpatient or outpatient may be paid only to the hospital.

Since the activation of edit 729F, Medicare administrative contractors (MACs) have experienced an increased volume of appeals from physicians and suppliers who have received denials for the TC of pathology services when they occurred on the same DOS as an outpatient hospital service. While most denials have been upheld, some denials have been overturned based on supporting documentation which demonstrates that the outpatient hospital service, although occurring on the same day, did not include services for which the hospital would have already been paid for the TC of a pathology service. This CR implements refinements to edit 729F (which denies TC of pathology claims when an outpatient hospital service occurs on the same DOS) in an effort to help reduce the number of claims inappropriately denied by the aforementioned edit during initial determination.

B. Policy: The TC of physician pathology services provided to a Medicare beneficiary who is <u>not</u> a hospital inpatient or hospital outpatient (at the time of the ordering/referring physician's service) is paid on the Medicare physician fee schedule (MPFS). Therefore, effective for TC of pathology claims processed on and after January 1, 2014, CWF shall incorporate additional bypass criteria to edit 729F to allow the TC of pathology claim when there is a claim in history from the ordering/referring physician for the same DOS as the TC of pathology claim <u>and</u> the ordering/referring physician's claim has a non-hospital place of service (POS).

While contractors are not required to identify and adjust claims previously denied by edit 729F, they may reprocess claims that meet the exception criteria described below that are brought to their attention by

suppliers. Suppliers may continue to appeal denied claims.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8399.1	Effective for claims processed on and after January 1, 2014, CWF shall revise edit 729F to include additional criteria to bypass the edit when <u>all</u> of the following conditions are present: 1. There is a paid claim in history for services rendered by the physician identified on the incoming TC of pathology claim as the ordering/referring physician; and 2. The POS on the ordering/referring physician claim in history is a non-hospital POS (for example, a POS other than 21 or 22)											X	
8399.1.1	If there is no paid claim in history from the physician who ordered/referred the pathology service, then continue to set edit 729F pursuant to the requirements in CR 5347 and any subsequent instructions related to the TC of pathology edits.											X	
8399.1.2	CWF shall update the IUR(s) associated with edit 729F to ensure they are consistent with the new bypass criteria.											X	
8399.2	Contractors are not required to identify previously denied claims for adjustment; however, contractors shall reopen and adjust any previously denied claims for the TC of pathology that are brought to their attention wherein the associated ordering/referring physician's claim in history contained a non-hospital POS.		X				X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility

		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
8399.3	MLN Article : A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.		X				X		

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Felicia Rowe, felicia.rowe@cms.hhs.gov (For claims processing questions) , Craig Dobyski, craig.dobyski@cms.hhs.gov (For policy related questions) , Ken Marsalek, kenneth.marsalek@cms.hhs.gov (For policy related questions)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
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