CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1561	**Date: JULY 25, 2008**
	Change Request 6042

This transmittal replaces Transmittal 1561, dated July 25, 2008. The only change is in the background section (Section I.A. of the business requirements), in the second sentence of that section, from the payment of TC will continue through December 31, 2008 to December 31, 2009. All other information remains the same.

This CR rescinds and replaces CR 6088, Transmittal 357 which was issued on July 7, 2008. CR 6088 was issued because the provision allowing payment for the subject services had elapsed and there was no legislative authority to continue beyond 6/30/08. The Medicare Improvements for Patients and Providers Act of 2008 which was enacted on July 15, 2008 extended the policy thus making CR 6088 invalid.

Subject: Medicare Improvements for Patients and Providers Act of 2008- Legislative Change Concerning Independent Laboratory Billing for the Technical Component of Physician Pathology Services.

I. SUMMARY OF CHANGES: This Change Request (CR) implements provider education activities to notify the independent laboratories eligible to bill the carrier for the technical component of physician pathology services provided in an inpatient or outpatient setting that they may continue to do so through December 31, 2009, regardless of the beneficiary's hospitalization status (inpatient or outpatient), in accordance with Medicare Improvements for Patients and Providers Act of 2008. It also instructs the carriers not to implement the business requirements of CR 5347 with respect to action for physician pathology services (See CR 5347, Transmittal 1221, issued and April 18, 2007).

New / Revised Material
Effective Date: July 1, 2008
Implementation Date: August 25, 2008

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
R	16/80/80.2.1/Technical Component of Physician Pathology Services to Hospital Patients

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their

operating budgets.

SECTION B: 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 obligated 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:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1561	Date: July 25, 2008	Change Request: 6042

This transmittal replaces Transmittal 1561, dated July 25, 2008. The only change is in the background section (Section I.A. of the business requirements), in the second sentence of that section, from the payment of TC will continue through December 31, 2008 to December 31, 2009. All other information remains the same.

This CR rescinds and replaces CR 6088, Transmittal 357 which was issued on July 7, 2008. CR 6088 was issued because the provision allowing payment for the subject services had elapsed and there was no legislative authority to continue beyond 6/30/08. The Medicare Improvements for Patients and Providers Act of 2008 which was enacted on July 15, 2008 extended the policy thus making CR 6088 invalid.

SUBJECT: Medicare Improvements for Patients and Providers Act of 2008 - Legislative Change to Independent Laboratory Billing for the Technical Component of Physician Pathology Services.

Effective Date: July 1, 2008

Implementation Date: August 25, 2008

I. GENERAL INFORMATION

A. Background:

The Medicare Improvements for Patients and Providers Act of 2008 was enacted on July 15, 2008. As a result, this change instructs the carriers to conduct provider education activities to notify the independent laboratories that those that qualify to bill under the Section 542 of the Benefits Improvement and Protection Act of 2000 (BIPA)/Section 732 of the Medicare Modernization Act (MMA)/ Section 104 of the Tax Relief and Health Care Act of 2006 (TRHCA)/ Section 104 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) for the technical component (TC) of the physician pathology services may continue to do so effective with DOS July 1, 2008, through December 31, 2009. This is an additional eighteen (18) months beyond the expiration date in the MMSEA. For more background and policy information regarding this change may refer to CR 5347, Transmittal 1221, issued on April 18, 2007 and CR 5943, Transmittal 1440, issued on February 7, 2008). This Change Request (CR) also instructs the carriers not to implement the business requirements specified in CR 5347/Transmittal 1221 with respect to actions for physician pathology services. This does not affect the business rules in terms of imaging services.

B. Policy:

In accordance with Section 136 of the Medicare Improvements for Patients and Providers Act of 2008**,** independent laboratories that qualify to bill for the TC of a physician pathology service furnished to a patient of a covered hospital are given an extension of an additional eighteen (18) months to continue to bill the carrier for these services through December 31, 2009. The independent laboratories that are eligible to bill for these services under the Section 136 provision may bill for these services regardless of the patient's hospitalization status (inpatient or outpatient) at the time that the service is performed.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6042.1	Carriers and A/B MACs shall not implement CR 5347 business requirements 5347.4-5347.8, 5347.10-5347.14, 5347.16-5347.17, 5347.20-5347.22, or 5347.26 with respect to actions for physician pathology services. All other requirements of CR 5347 remain in effect. (See CR 5347, Transmittal 1221, issued on April 18, 2007.)	X			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6042.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/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 site 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 your 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						
6042.3	Carriers and A/B MACs shall conduct provider education activities to notify independent laboratories that those that qualify to bill for the TC of physician pathology services furnished to a hospital patient under the MMA Section 732/BIPA542/TRHCA Section 104/MMSEA Section 104 provision that they may continue to bill the carrier for these services through Dec 31, 2009, in accordance with the Medicare Improvements for Patients and Providers Act of 2008 Act of 2008 provision.	X			X						
6042.3.1	For consistency, carriers and A/B MACs shall use the language contained in the MLN Matters provider education article prepared for this change request for any supplemental provider education materials.	X			X						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Wendy Knarr at Wendy.Knarr@cms.hhs.gov or dial relay #711 then have agent call (410) 786-0843.

Post-Implementation Contact(s): Contact the appropriate Regional Office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs) and Carriers,* use the following statement:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs),* use the following statement:

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 obligated 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.

80.2.1 - Technical Component (TC) of Physician Pathology Services to Hospital Patients

(Rev. 1561; Issued: 07-25-08; Effective Date: 07-01-08; Implementation Date: 08-25-08)

Section 542 of the Benefits Improvement and Protection Act of 2000 (BIPA) provides that the Medicare carrier can 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. This provision applies to TC services furnished during the 2-year period beginning on January 1, 2001. Administrative extensions of this provision, and new provisions established under Section 732 of the Medicare Modernization Act (MMA)*/ Section 104 of the Tax Relief and Health Care Act (TRHCA) of 2006/ Section 104 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA)/Section136 of* the *Medicare Improvements for Patients and Providers Act of 2008 (MIPPA),* allow the carrier to continue to pay for this service through *December 31, 2009.*

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 a laboratory furnished the TC of physician pathology services to fee-for-service Medicare beneficiaries who were hospital inpatients or outpatients and submitted claims for payment for the TC to a carrier. The TC could have been submitted separately or combined with the professional component and reported as a combined service.

The term "fee-for-service Medicare beneficiary" means an individual who:

1. Is entitled to benefits under Part A or enrolled under Part B of title XVIII or both; and

2. Is not enrolled in any of the following:

    a. A Medicare + Choice plan under Part C of such title;

    b. A plan offered by an eligible organization under §1876 of the Act;

    c. A program of all-inclusive care for the elderly under §1894 of the Act; or

    d. A social health maintenance organization demonstration project established under §4108(b) of the Omnibus Budget Reconciliation Act of 1987.

The following examples illustrate the application of the statutory provision to arrangements between hospitals and independent laboratories.

In implementing BIPA §542/MMA §732/ *TRHCA §104/ MMSEA §104/ MIPPA §136,* the carriers should consider as independent laboratories those entities that it has previously recognized and paid as independent laboratories.

An independent laboratory that has acquired another independent laboratory that had an arrangement on July 22, 1999, with a covered hospital, can bill the TC of physician

pathology services for that hospital's inpatients and outpatients under the physician fee schedule *through December 31, 2009.*

EXAMPLE 1:

Prior to July 22, 1999, independent laboratory A had an arrangement with a hospital in which this laboratory billed the carrier for the TC of physician pathology services. In July 2000, independent laboratory B acquires independent laboratory A. Independent laboratory B bills the carrier for the TC of physician pathology services for this hospital's patients in 2001 and 2002.

If a hospital is a covered hospital, any independent laboratory that furnishes the TC of physician pathology services to that hospital's inpatients or outpatients can bill the carrier for these services furnished in 2001 and 2002.

EXAMPLE 2:

As of July 22, 1999, the hospital had an arrangement with an independent laboratory, laboratory A, under which that laboratory billed the carrier for the TC of physician pathology service to hospital inpatients or outpatients. In 2001, the hospital enters into an arrangement with a different independent laboratory, laboratory B, under which laboratory B wishes to bill its carrier for the TC of physician pathology services to hospital inpatients or outpatients. Because the hospital is a "covered hospital," independent laboratory B can bill its carrier for the TC of physician pathology services to hospital inpatients or outpatients.

If the arrangement between the independent laboratory and the covered hospital limited the provision of TC physician pathology services to certain situations or at particular times, then the independent laboratory can bill the carrier only for these limited services.

An independent laboratory that furnishes the TC of physician pathology services to inpatients or outpatients of a hospital that is not a covered hospital may not bill the carrier for TC of physician pathology services furnished to patients of that hospital.

An independent laboratory that has an arrangement with a covered hospital should forward a copy of this agreement or other documentation to its carrier to confirm that an arrangement was in effect between the hospital and the independent laboratory as of July 22, 1999. This documentation should be furnished for each covered hospital the independent laboratory services. If the laboratory did not have an arrangement with the covered hospital as of July 22, 1999, but has subsequently entered into an arrangement, then it should obtain a copy of the arrangement between the predecessor laboratory and the covered hospital and furnish this to the carrier. The carrier maintains a hard copy of this documentation for postpayment reviews.

Effective *on or after January 1, 2010,* only the hospital may bill for the TC of a physician pathology service provided to an inpatient or outpatient. In addition, the hospital cannot bill under the OPPS for the TC of physician pathology services if the independent laboratory that services that hospital outpatient is receiving payment from its carrier under the physician fee schedule.