



News Flash – The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that reporting for the 2007 PQRI on claims for dates of service as of July 1, 2007, has begun. Eligible professionals can now start participating in the PQRI by simply reporting the appropriate quality measure data on claims submitted to their Medicare claims processing contractor. Remember, all your informational needs can be met by visiting the PQRI website at <http://www.cms.hhs.gov/PQRI>. Here you will find educational resources, including the PQRI Tool Kit, and links to our most Frequently Asked Questions (FAQs).

MLN Matters Number: MM5675

Related Change Request (CR) #: 5675

Related CR Release Date: July 13, 2007

Effective Date: April 1, 2007

Related CR Transmittal #: R1295CP

Implementation Date: October 1, 2007

Laboratory and Radiology: Adjustment to Medicare System Common Working File (CWF) Duplicate Claim Edit for the Technical Component (TC) of Radiology and Pathology Laboratory Services Provided to Hospital Patients

Note: This article was revised on September 27, 2007, to include the “bold and italicized” language in the “GO Light” section on page 2. Basically, this added language just reminds affected providers of the need to resubmit certain claims on or after October 1, 2007. All other information remains the same.

Provider Types Affected

Radiology suppliers, clinical diagnostic laboratories, and other providers billing Medicare carriers or Part A/B Medicare Administrative Contractors (A/B MACs) for the TC of **radiology and pathology** services provided to Medicare fee-for-service hospital inpatients.

Provider Action Needed



STOP – Impact to You

Previously the Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 5347 that established duplicate claims edits, which included consideration of the admission and discharge dates of a hospital stay in identifying duplicate claims for radiology and pathology services.

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**CAUTION – What You Need to Know**

Effective with implementation of CR5675 on October 1, 2007, claims with dates of service on or after April 1, 2007, **will be paid that provide radiology and pathology services to Medicare beneficiaries on the day of admission and the day of discharge during an inpatient hospital stay.**

**GO – What You Need to Do**

Make certain that your billing staffs are aware of these changes. *If providers, radiology suppliers, or clinical diagnostic laboratories had claims with dates of service on or after April 1, 2007, that would have been paid had these edits been in place on April 1, 2007, they should resubmit those claims on or after October 1, 2007. Medicare carriers and A/B MACs will be ready to process resubmitted claims using these new edits as of October 1, 2007. Claims resubmitted on or after October 1, 2007, will not deny as duplicates, since they were not paid initially. For information regarding recoupment/demand letters, see Chapter 4, Section 90.2 of the Medicare Financial Management Manual located at <http://www.cms.hhs.gov/manuals/downloads/fin106c04.pdf> on the CMS website.*

Background

This CR is being implemented to avoid denying claims that were legitimately provided to beneficiaries on the admission and discharge dates. The general rule is that the technical component (TC) of radiology services provided during an inpatient stay may be billed only by the admitting hospital. Radiology suppliers that render services to beneficiaries in an inpatient stay may not bill the Medicare carrier for the technical portion of the service.

Also, the TC of physician pathology services provided to a hospital inpatient may be billed only by the admitting hospital. Independent laboratories have been instructed that they may not bill for these services after December 31, 2007 per CR 5468 (Transmittal 1148, issued Jan 5, 2007). **The exception is that imaging and pathology services performed on the admission date and discharge date by entities other than the admitting hospital are separately payable.**

Also, note that carriers and A/B MACs will not reprocess claims already processed, but they will adjust previously processed claims if affected providers bring such claims to the attention of their carrier or A/B MAC.

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Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR5675) issued to your Medicare carrier or A/B MAC. That instruction may be viewed by going to

<http://www.cms.hhs.gov/Transmittals/downloads/R1295CP.pdf> on the CMS website.

If you have questions, please contact your Medicare carrier or A/B MAC, at their toll-free number which may be found at

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

CR 5347 implemented a process to prevent payments of the TC of radiology services furnished to an inpatient of a hospital by any entity other than the admitting hospital. This CR may be reviewed by clicking on

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5347.pdf> on the CMS website.

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