CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1046	**Date: SEPTEMBER 1, 2006**
	Change Request 5210

SUBJECT: Independent Laboratory Billing for the Technical Component (TC) of Physician Pathology Services

I. SUMMARY OF CHANGES: Section 732 of the Medicare Modernization Act (MMA) extended the provision of Section 542 of the Benefits Improvement Act of 2000 (BIPA) that allows independent laboratories to continue to bill under the physician fee schedule for the technical component of physician pathology services furnished to patients of a covered hospital. In the final physician fee schedule published in the Federal Register on November 2, 1999, CMS stated that it would implement a policy to pay only the hospital for the TC of physician pathology services furnished to hospital patients. This transmittal instructs the carriers to conduct provider education activities to notify independent laboratories that they may no longer bill for these services after the MMA provision expires on December 31, 2006.

New / Revised Material
Effective Date: December 1, 2006
Implementation Date: December 1, 2006

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

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budget.

IV. ATTACHMENTS:

One-Time Notification

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

Attachment – One-Time Notification

Pub. 100-04	Transmittal: 1046	Date: September 1, 2006	Change Request 5210

SUBJECT: Independent Laboratory Billing for the Technical Component (TC) of Physician Pathology Services

I. GENERAL INFORMATION

A. Background: The technical component (TC) of physician pathology services refers to the preparation of the slide, involving tissue or cells that a pathologist will interpret. (In contrast, the pathologist's interpretation of the slide is the professional component (PC) service. If this service is furnished by the hospital pathologist for a hospital patient, it is separately billable. If the independent laboratory's pathologist furnishes the PC service, it is usually billed with the TC service as a combined service.)

In the final physician fee schedule regulation published in the ***Federal Register*** on November 2, 1999, CMS stated that it would implement a policy to pay only the hospital for the TC of physician pathology services furnished to hospital patients. Prior to this proposal, any independent laboratory could bill the carrier under the physician fee schedule for the TC of physician pathology services for hospital patients. As pointed out in the final rule, this policy has contributed to the Medicare program paying twice for the TC service, first through the inpatient prospective payment rate to the hospital where the patient is an inpatient, and again to the independent laboratory that bills the carrier, instead of the hospital, for the TC service.

The final 1999 regulation (42 CFR 415.130) provided that, for services furnished on or after January 1, 2001, the carriers would no longer pay claims to the independent laboratory under the physician fee schedule for the TC of physician pathology services for hospital patients. Ordinarily, the provisions in the final physician fee schedule are implemented in the following year. In this case, the provision was delayed one year, at the request of the industry, to allow independent laboratories and hospitals sufficient time to negotiate arrangements.

Before this regulation was implemented, the Benefits Improvement and Protection Act of 2000 (BIPA) was enacted. Section 542 of BIPA provided that the carrier 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. (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 inpatients or outpatients and submitted claims for payment for the TC to a carrier.)

The BIPA-542 provision was effective for services furnished in 2001 and 2002. CMS administratively extended this provision for 2003 and 2004.

Section 732 of the Medicare Modernization Act (MMA) extended this provision for services furnished in 2005 and 2006. When this provision expires, the regulation at 42 CFR 415.130 will take effect as this regulation's implementation has only been delayed by the legislation.

Section 542 of BIPA required the GAO to report on the number of hospitals affected by this provision, their service volumes and the effect of the termination of this payment provision on hospitals and laboratories. The GAO submitted their final report in September 2003. It suggested that the Congress consider not reinstating this provision and recommended that CMS terminate the policy of allowing laboratories to receive direct payment.

This instruction announces the agency's intention to implement the final regulations, at 42 CFR 415.130, included in the 1999 final physician fee schedule regulations.

B. Policy: Independent laboratories may not bill for the TC of physician pathology services furnished to a patient of a hospital after December 31, 2006. This policy enforces the regulation at 42 CFR 415.130. Carriers shall conduct provider education activities to notify independent laboratories that they may no longer bill for these services after December 31, 2006. A future Change Request with additional carrier instructions for implementing the system edits to enforce this policy is forthcoming.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5210.1	Carriers shall notify independent laboratories that they may not bill for the TC of physician pathology services when furnished to a hospital inpatient or outpatient after December 31, 2006.			X						

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5210.2	A provider education article related to this instruction will be available at 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 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. 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						
5210.3	Carriers shall conduct provider education activities to notify independent laboratories that they may no longer bill for the TC of physician pathology services furnished to a hospital patient after the MMA Section 732 provision expires on December 31, 2006.			X						
5210.3.1	For consistency, carriers shall use the language contained in the MLN Matters provider education article prepared for this Change Request for any supplemental provider education materials.			X						

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: December 1, 2006 **Implementation Date:** December 1, 2006 **Pre-Implementation Contact(s):** James Menas 410-786-4507, Susan Webster 410-786-3384 **Post-Implementation Contact(s):** Appropriate Regional Office	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

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