CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2714	**Date: May 24, 2013**
	Change Request 8013

SUBJECT: Updates to Chapter 12 and Chapter 16 of the Medicare Claims Processing Manual to Revise Instructions Regarding the Technical Component (TC) of Pathology Services Furnished to Hospital Patients

I. SUMMARY OF CHANGES: This Change Request communicates revisions to the Physicians/Nonphysician Practitioners and Laboratory Services chapters of the Medicare Claims Processing Manual (Publication 100-04, Chapters 12 and 16) so that billing and claims processing instructions contained within are up-to-date with regards to billing for the Technical Component (TC) of physician pathology services furnished to hospital patients.

EFFECTIVE DATE: July 1, 2012
IMPLEMENTATION DATE: June 25, 2013

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	12 / 60 / Payment for Pathology Services
R	16 / 80.2.1 / Technical Component (TC) of Physician Pathology Services to Hospital Patients

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):
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:
Business Requirements
Manual Instruction
**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2714	Date: May 24, 2013	Change Request: 8013

SUBJECT: Updates to Chapter 12 and Chapter 16 of the Medicare Claims Processing Manual to Revise Instructions Regarding the Technical Component (TC) of Pathology Services Furnished to Hospital Patients

EFFECTIVE DATE: July 1, 2012
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I. GENERAL INFORMATION

A. Background: Under previous law, including, most recently, Section 3006 of the *Middle Class Tax Relief and Job Creation Act of 2012*,a statutory moratorium allowed certain practitioners and suppliers (such as pathologists and Independent Laboratories) meeting specific criteria to bill a carrier or an A/B MAC for the Technical Component (TC) of physician pathology services furnished to hospital patients. This moratorium expired on June 30, 2012. Therefore, pathologists and independent laboratories that provide the TC of physician pathology services furnished to hospital patients may no longer bill for and receive Medicare payment for these services, effective for claims with dates of service on or after July 1, 2012.

B. Policy: This Change Request communicates revisions to the Physicians/Nonphysician Practitioners chapter and Laboratory Services chapter of the Medicare Claims Processing Manual (Publication 100-04, Chapter 12 and Chapter 16 respectively) so that billing and claims processing instructions contained within are up-to-date with regards to billing for the TC of physician pathology services furnished to hospital patients. Contractors shall be in compliance with the instructions found in these chapters.

For services furnished on or after July 1, 2012, an independent laboratory may not bill the Medicare contractor (and the Medicare contractor may not pay) for the TC of a physician pathology service furnished to a hospital inpatient or outpatient.

Payment is not made under the physician fee schedule for TC services furnished in institutional settings, e.g., hospital inpatient and outpatient settings, where the TC service is bundled into the facility payment. However, we are clarifying the policy to indicate that payment is made under the physician fee schedule for TC services furnished in institutional settings, e.g., an ambulatory surgery center (ASC), where the TC service is not bundled into the facility payment.

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	
8013.1	Contractors shall be in compliance with the instructions found in the CMS Internet Only Manual (IOM) Publication 100-04, Chapter 12 - Physicians/Nonphysician Practitioners, Section 60 and Chapter 16 – Laboratory Services, Section		X				X						

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	80.2.1												
8013.2	Contractors shall not pay for the TC of physician pathology services furnished by an independent laboratory, on or after July 1, 2012, to hospital inpatients or outpatients.		X				X						
8013.3	Contractors shall make payment under the physician fee schedule for TC services furnished in institutional settings, e.g., an ambulatory surgery center (ASC), where the TC service is not bundled into the facility payment.		X				X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
	None								

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): Kenneth Marsalek, kenneth.marsalek@cms.hhs.gov , Eric Coulson, eric.coulson@cms.hhs.gov

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):
No additional funding will be provided by CMS; Contractors activities are to be carried out with 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 do 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.

Medicare Claims Processing Manual
Chapter 12 - Physicians/Nonphysician Practitioners

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((Rev.2714, Issued: 05-24-13)

Transmittals for Chapter 12

60 – Payment for Pathology Services

60 - Payment for Pathology Services

(Rev.2714, Issued: 05-24-13, Effective: 07-01-12 Implementation: 06-25, 13)

A. *Payment for Professional Component (PC) Services*

Payment may be made under the *physician* fee schedule for the professional component of physician laboratory or physician pathology services furnished to hospital inpatients or outpatients by hospital physicians or by independent laboratories, if they qualify as the *re-assignee* for the physician service.

B. Payment for Technical Component (TC) Services

1. General Rule

Payment is not made under the physician fee schedule for TC services furnished in institutional settings where the TC service is bundled into the facility payment, e.g., hospital inpatient and outpatient settings. Payment is made under the physician fee schedule for TC services furnished in institutional settings where the TC service is not bundled into the facility payment, e.g., an ambulatory surgery center (ASC). Payment may be made under the physician fee schedule for the TC of physician pathology services furnished by an independent laboratory, or a hospital if it is acting as an independent laboratory, to non-hospital patients. The physician fee schedule identifies physician laboratory or physician pathology services that have a TC service.

2. TC Services Furnished by Independent Laboratories to Hospital Inpatients and Outpatients

- *For services furnished on or after July 1, 2012, an independent laboratory may not bill the Medicare contractor (and the Medicare contractor may not pay) for the TC of a physician pathology service furnished to a hospital inpatient or outpatient.*
- *For services furnished prior to July 1, 2012, p*ayment may be made under the fee schedule, as noted below, for the *(TC)* of pathology services furnished by an independent laboratory to hospital inpatients or outpatients.

CMS published a final regulation in 1999 that would no longer allow independent laboratories to bill under the physician fee schedule for the TC of physician pathology services. The implementation of this regulation was delayed by Section 542 of the Benefits and Improvement and Protection Act of 2000 (BIPA). Section 542 allows the Medicare carrier to 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 is applicable to TC services furnished *January 1,* 2001 *through June 30, 2012.*

For this provision, a covered hospital is 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:

- Is entitled to benefits under Part A or enrolled under Part B of title XVIII or both; and
- Is not enrolled in any of the following: A Medicare + Choice plan under Part C of such title; a plan offered by an eligible organization under §1876 of the Social Security Act; a program of all-inclusive care for the elderly under §1894; or a social health maintenance organization demonstration project established under Section 4108 of the Omnibus Budget Reconciliation Act of 1987.

In implementing Section 542, the *contractors* should consider as independent laboratories those entities that it has previously recognized as independent laboratories.

An independent laboratory that has acquired another independent laboratory that had an arrangement of 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.

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 the TC of physician pathology services during the time §542 is in effect.

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.

The *contractor* shall require independent laboratories that had an arrangement, on or prior to July 22, 1999 with a covered hospital, to bill for the technical component of physician pathology services to provide a copy of this agreement, or other documentation substantiating that an arrangement was in effect between the hospital and the independent laboratory as of this date. The independent laboratory must submit this documentation for each covered hospital that the independent laboratory services.

C. Physician Laboratory and Pathology Services

Physician laboratory and pathology services are limited to:

- Surgical pathology services;
- Specific cytopathology, hematology and blood banking services that have been identified to require performance by a physician and are listed below;
- Clinical consultation services that meet the requirements in subsection *3* below; and
- Clinical laboratory interpretation services that meet the requirements and which are specifically listed in subsection *4* below.

1. Surgical Pathology Services

Surgical pathology services include the gross and microscopic examination of organ tissue performed by a physician, except for autopsies, which are not covered by Medicare.

Depending upon circumstances and the billing entity, the *contractors* may pay professional component, technical component or both.

2. Specific Hematology, Cytopathology and Blood Banking Services

Cytopathology services include the examination of cells from fluids, washings, brushings or smears, but generally excluding hematology. Examining cervical and vaginal smears are the most common service in cytopathology. Cervical and vaginal smears do not require interpretation by a physician unless the results are or appear to be abnormal. In such cases, a physician personally conducts a separate microscopic evaluation to determine the nature of an abnormality. This microscopic evaluation ordinarily does require performance by a physician. When medically necessary and when furnished by a physician, it is paid under the fee schedule.

For services furnished prior to January 1, 1999, *contractors* pay separately under the physician fee schedule for the interpretation of an abnormal pap smear furnished to a hospital inpatient by a physician. They must pay under the clinical laboratory fee schedule for pap smears furnished in all other situations. This policy also applies to screening pap smears requiring a physician interpretation. For services furnished on or after January 1, 1999, *contractors* allow separate payment for a physician's interpretation of a pap smear to any patient (i.e., hospital or non-hospital) as long as: (1) the laboratory's screening personnel suspect an abnormality; and (2) the physician reviews and interprets the pap smear.

This policy also applies to screening pap smears requiring a physician interpretation and described in the National Coverage Determination Manual and Chapter 18. These services are reported under codes P3000 or P3001.

Physician hematology services include microscopic evaluation of bone marrow aspirations and biopsies. It also includes those limited number of peripheral blood smears which need to be referred to a physician to evaluate the nature of an apparent abnormality identified by the technologist. These codes include 85060, 38220, 85097, and 38221.

Contractors pay the *PC* for the interpretation of an abnormal blood smear (code 85060) furnished to a hospital inpatient by a hospital physician or an independent laboratory.

For other hematology codes, payment may be made for the *PC* component if the service is furnished to a patient by a hospital physician or independent laboratory. In addition, payment may be made for these services furnished to patients by an independent laboratory.

Blood banking services of hematologists and pathologists are paid under the physician fee schedule when analyses are performed on donor and/or patient blood to determine compatible donor units for transfusion where cross matching is difficult or where contamination with transmissible disease of donor is suspected.

The blood banking codes are 86077, 86078, and 86079 and represent professional component only services.

3. Clinical Consultation Services

Clinical consultations are paid under the physician fee schedule only if they:

a. Are requested by the patient's attending physician;

b. Relate to a test result that lies outside the clinically significant normal or expected range in view of the condition of the patient;

c. Result in a written narrative report included in the patient's medical record; and

d. Require the exercise of medical judgment by the consultant physician.

Clinical consultations are professional component services only*, i.e., t*here is no *TC service.* The clinical consultation codes are 80500 and 80502.

Routine conversations held between a laboratory director and an attending physician about test orders or results do not qualify as consultations unless all four requirements are met. Laboratory personnel, including the director, may from time to time contact attending physicians to report test results or to suggest additional testing or be contacted by attending physicians on similar matters. These contacts do not constitute clinical consultations. However, if in the course of such a contact, the attending physician requests a consultation from the pathologist, and if that consultation meets the other criteria and is properly documented, it is paid under the fee schedule.

EXAMPLE: A pathologist telephones a surgeon about a patient's suitability for surgery based on the results of clinical laboratory test results. During the course of their conversation, the surgeon ask*s* the pathologist whether, based on test results, patient history and medical records, the patient is a candidate for surgery. The surgeon's request requires the pathologist to render a medical judgment and provide a consultation. The pathologist follows up his/her oral advice with a written report and the surgeon notes in the patient's medical record that he/she requested a consultation. This consultation is paid under the fee schedule.

In any case, if the information could ordinarily be furnished by a nonphysician laboratory specialist, the service of the physician is not a consultation payable under the fee schedule.

See the Program Integrity Manual for guidelines for related data analysis to identify inappropriate patterns of billing for consultations.

4. Clinical Laboratory Interpretation Services

Only clinical laboratory interpretation services, which meet the criteria in subsections *C.3.a, c, and d,* are billable under the *physician* fee schedule. *These codes have a PC/TC indicator of "6" on the Medicare Physician Fee Schedule database.* These services are reported under the clinical laboratory code with modifier 26. These services can be paid under the physician fee schedule if they are furnished to a patient by a hospital pathologist or an independent laboratory. Note that a hospital's standing order policy can be used as a substitute for the individual request by the patient's attending physician. *Contractors* are not allowed to revise CMS's list to accommodate local medical practice. The CMS periodically reviews this list and adds or deletes clinical laboratory codes as warranted.

D. Global Billing

Billing globally for services that are split into separate PC and TC services is only possible when the PC and TC are furnished by the same physician or supplier entity. For example, where the PC and the TC of a diagnostic service are provided in the same service location, this is reflected as the address entered into Item 32 on CMS Form 1500, which provides the ZIP Code to pay the right locality/GPCI. In this case, the

physician/entity may bill globally. However, if the PC and the TC are each provided in different service locations (enrolled practice locations), the PC and the TC must be separately billed.

Merely applying the same place of service (POS) code to the PC and the TC does not permit global billing for any diagnostic procedure.

Medicare Claims Processing Manual
Chapter 16 - Laboratory Services

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

((Rev.2714, Issued: 05-24-13, Effective: 07-01-12 Implementation: 06-25, 13)

Section 542 of the Benefits Improvement and Protection Act of 2000 (BIPA) provides that the Medicare A/B MAC/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); Section 136 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA); Section 3104 of the Patient Protection and Affordable Care Act (PPACA)*; Section 105 of the Medicare & Medicaid Extenders Act of 2010 (MMEA); and Section 3006 of the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA)* allow the A/B MAC/carrier to continue to pay for this service through *June 30, 2012*.

For this provision, covered hospital means a hospital that had an arrangement with an independent laboratory *or other entity* that was in effect as of July 22, 1999, under which *the* laboratory *or other entity* 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 A/B MAC/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 *and/or other entities*.

In implementing BIPA §542; MMA §732; TRHCA §104; MMSEA §104; MIPPA §136; *and* PPACA § 3104*; MMEA § 105; and MCTRJCA § 3006*, the A/B MAC/carriers should consider as independent laboratories *any entity* that it has previously recognized and paid as *an* independent *laboratory as of July 22, 1999.*

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 *June 30, 2012*.

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 forward*.

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 forward up to June 30, 2012 (see note below on last paragraph).*

EXAMPLE 2:

As of July 22, 1999, the hospital had an arrangement with an independent laboratory, laboratory A, under which that laboratory billed the A/B MAC/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 A/B MAC/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 A/B MAC/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 A/B MAC/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 A/B MAC/carrier for TC of physician pathology services furnished to patients of that hospital.

An independent laboratory *or other entity* that has an arrangement with a covered hospital should forward a copy of this agreement or other documentation to its A/B MAC/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 *or other entity* services. If the laboratory *or other entity* 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 *or other entity* and the covered hospital and furnish this to the A/B MAC/carrier. The A/B MAC/carrier maintains a hard copy of this documentation for postpayment reviews.

Please Note: Effective on or after *July 1, 2012*, only the hospital may bill for the TC of a physician pathology service provided to an inpatient or outpatient. *Neither example 1 nor example 2 above will apply for claims with dates of service on or after July 1, 2012.*