

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



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- ["The Medicare Coverage of Imaging Services,"](#) Fact Sheet, ICN 907164, Downloadable only.

MLN Matters® Number: MM8399

Related Change Request (CR) #: CR 8399

Related CR Release Date: August 9, 2013

Effective Date: January 1, 2014

Related CR Transmittal #: R12760TN

Implementation Date: January 6, 2014

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

Provider Types Affected

This MLN Matters® Article is intended for physicians and suppliers submitting claims to Medicare contractors (carriers and A/B Medicare Administrative Contractors (A/B MACs)) for services to Medicare beneficiaries.

What You Need to Know

This article is based on Change Request (CR) 8399 which informs Medicare contractors about the changes to the claims processing systems to allow the Technical Component (TC) of a pathology claim when there is a claim in history from the ordering/referring physician for the same Date of Service (DOS) as the TC of the pathology claim and when the place of service on the ordering/referring physician's claim for physician services is a non-hospital place of service, i.e., it is not 21 or 22. The TC of physician pathology services provided to a Medicare beneficiary who is not 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).

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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.

Note: It is imperative that physicians and suppliers who submit claims for TC of physician pathology services ensure they are reporting the correct NPI for the ordering/referring physician on their claims.

Background

Change Request (CR) 5347 (Transmittal 1221, issued on April 18, 2007) implemented a process to prevent payments for the 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 CR5347, 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 contractors 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. CR8399 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. Therefore, effective for the TC of pathology claims processed on and after January 1, 2014, the CWF shall incorporate additional bypass criteria to edit 729F to allow the TC of a pathology claim when there is a claim in

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history from the ordering/referring physician for the same DOS as the TC of the pathology claim and the ordering/referring physician's claim has a non-hospital place of service.

Additional Information

The official instruction, CR8399 issued to your Medicare contractor regarding this change may be viewed at <http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1276OTN.pdf> on the CMS website.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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