CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1221	**Date: APRIL 18, 2007**
	Change Request 5347

NOTE: This instruction is being re-communicated to clarify that CR 5468, delayed the billing date for the technical component of physician pathology services based on the Tax Relief and Health Care Act of 2006.This transmittal rescinds and replaces Transmittal 1098 issued November 2, 2006. This Change Request is being reissued to extend the billing date for the technical component (TC) of physician pathology services specified in chapter 16, section 80.2.1, issued via CR 5468, Transmittal 1148 on January 5, 2007. Transmittal 1148 delays the implementation of the pathology TC until January 1, 2008. The Transmittal Number, Date Issued and all other information remains the same.

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

I. SUMMARY OF CHANGES: Updates are being incorporated in Chapter 13 to indicate CWF editing that is being put in place to prevent payment by a carrier for the TC of a radiology service provided during an inpatient stay. Updates are being incorporated in Chapter 16 to announce editing that is being put in place to prevent payment by a carrier for a TC of a pathology service rendered during an inpatient stay or for the same date of service as an outpatient service.

New/Revised Material
Effective Date: April 1, 2007
Implementation Date: April 2, 2007

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

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	13/20/20.2.1/Hospital and Skilled Nursing Facility Patients
R	16/80/80.2.1Technical Component of Physician Pathology Services to Hospital Patients

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1221	Date: April 18, 2007	Change Request 5347

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

I. GENERAL INFORMATION

A. Background

Radiology Services

The Social Security Act § 1862(a)(14) and 42 CFR § 411.15(m) requires that when the TC of a radiology service is furnished to an inpatient of a hospital by any entity other than the hospital the TC is excluded from coverage unless they are performed under arrangement in which the hospital must bill the intermediary. Therefore, when the TC of a radiology service is provided to an inpatient under arrangement by a physician/supplier only the hospital may bill Medicare for the services.

The Office of Inspector General (OIG) has submitted a draft report to the Centers for Medicare and Medicaid Services (CMS) which identified improper payments to carriers for the technical component (TC) of radiology services provided to hospital inpatients by suppliers of radiology services. The OIG draft study found that Medicare paid twice; once to the hospital that billed the intermediary and again to the radiology supplier or physician that billed the carrier.

This transmittal implements changes to ensure that we do not pay for radiology services billed to the carrier when the beneficiary is an inpatient at a hospital.

Physician Pathology Services

Current Medicare rules allow either the hospital or the supplier performing the technical component (TC) of physician pathology laboratory services to bill the intermediary or the carrier respectively for these services. This policy has contributed to the Medicare program paying twice for the TC of the service, first through the Prospective Payment System (PPS) to the hospital and again to the supplier that bills the carrier, instead of the hospital, for the TC 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. Again, as pointed out in the final rule, this policy has contributed to the Medicare program paying twice for the TC service, first through the prospective payment rate to the hospital where the beneficiary is a patient and again to the independent laboratory that bills the carrier, instead of the hospital, for the TC service.

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. Additionally, new provisions established under Section 542 of the Benefits Improvement and Protection Act of 2000 (BIPA), administrative extensions of these provisions, and provisions established under Section 732 of the Medicare Modernization Act (MMA), have further delayed the policy change proposed in the regulation. Therefore, during this time, the carriers have continued 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 patients of a hospital and submitted claims for payment for the TC to a carrier.) However, the aforementioned MMA provision sunsets on December 31, 2006. Therefore, this instruction will implement the final regulations at 42 CFR §415.130 (d), included in the 1999 final physician fee schedule regulations, which provides that, in effect, the TC of a physician pathology service provided to a hospital inpatient or outpatient may be paid only to the hospital.

Corrective Action

Effective April 1, 2007, for claims with a date of service on or after January 1, 2007, CMS shall install systems edits in our Common Working File (CWF) to prevent additional improper payments to radiology suppliers, physicians and independent laboratories for TC or globally billed radiology/physician pathology services provided to beneficiaries during a hospital stay.

Beginning in the first quarter of calendar year 2007, the CMS will provide the CWF System Maintainer and the carriers with a file containing the radiology and physician pathology Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the CWF duplicate claim edit. In addition, the CMS will make quarterly updates to the file to add and/or delete codes, as needed, in conjunction with the Medicare Physician Fee Schedule Database (MPFSDB) quarterly updates. CMS will notify the CWF System Maintainer and the carriers when the file/updates are available.

B. Policy: The TC of radiology services provided during an inpatient stay may be billed only by the hospital. Radiology suppliers that render services to beneficiaries in an inpatient stay shall not bill the Medicare carrier for the technical portion of the service.

In addition, the TC of physician pathology services provided to a hospital inpatient or outpatient may be billed only by the hospital. Independent laboratories have been instructed that they may not bill for these services after December 31, 2006.

Based on the CWF line item rejects, carriers shall deny the TC or globally billed radiology and physician pathology service line items that should be bundled to the hospital. Appeal rights shall be offered on all denials. Standard systems shall develop, and along with carriers shall implement, an automated response resolution process whereby when they receive a reject from CWF, they shall pay those services correctly billed and deny only those services on the claim incorrectly billed to them.

CWF shall allow an override of the reject for carrier use, when a physician or supplier successfully appeals a claim denial made under this policy. If the carrier determines that separate payment otherwise meets Medicare payment policies, the carrier may use the override code to allow that service to process through CWF to payment. The override code will be specified in the CWF documentation.

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	
5347.1	The CWF System Maintainer shall create an edit to reject a Part B TC or globally billed radiology service line item received on or after April 1, 2007, for dates of service on or after January 1, 2007, with a service date that falls within the admission and discharge dates, inclusive, of a covered hospital inpatient stay posted to the CWF.								X	
5347.1.1	The CWF System Maintainer shall implement the edit to reject a Part B TC or globally billed radiology service using the file of radiology HCPCS code provided during the first quarter of 2007.								X	
5347.1.2	Upon notification from CMS, the CWF System Maintainer shall implement quarterly updates to the edit to reject a Part B TC or globally billed radiology service.								X	
5347.2	The CWF System Maintainer shall create an edit to reject a Part B TC or globally billed physician pathology service line item received on or after April 1, 2007, for dates of service on								X	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	or after January 1, 2007, that falls within the admission and discharge dates, inclusive, of a covered hospital inpatient stay posted to the CWF.									
5347.2.1	The CWF System Maintainer shall implement the edit to reject a Part B TC or globally billed physician pathology service using the file of radiology HCPCS code provided during the first quarter of 2007.								X	
5347.2.2	Upon notification from CMS, the CWF System Maintainer shall implement quarterly updates to the edit to reject a Part B TC or globally billed physician pathology service.								X	
5347.3	Effective for claims received on or after April 1, 2007, the CWF shall reject and the carrier shall deny a service line item for a date of service on or after January 1, 2007, for a Part B TC or globally billed radiology service with a service date that falls within the admission and discharge dates, inclusive, of a covered hospital inpatient stay posted to the CWF.			X			X		X	
5347.4	Effective for claims received on or after April 1, 2007, for claims with dates of service on or after January 1, 2007, the CWF shall reject and the carrier shall deny a Part B TC or globally billed physician pathology service with a date of service that falls within the admission and discharge dates, inclusive, of a covered hospital inpatient stay posted to the CWF.			X			X		X	
5347.5	Effective for claims received on or after April 1, 2007, for claims with dates of service on or after January 1, 2007, the CWF shall reject and the carrier shall deny a Part B TC or globally billed physician pathology service with a date of service that matches the date of service of a hospital outpatient bill (bill types 13X, 85X) that is posted to the CWF.			X			X		X	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5347.6	The carrier shall use Remittance Advice Reason Code 109 ("Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.") when denying a service line item Part B TC or globally billed radiology or physician pathology service with a service date that falls within the admission and discharge dates, inclusive, of a covered hospital inpatient stay posted to the CWF.			X			X			
5347.7	The carrier shall use Remittance Advice Reason Code 109 ("Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.") when denying a service line item billed by a physician/supplier for a Part B TC or globally billed physician pathology service because the service date matches the date of service of a hospital outpatient bill (bill types 13X, 85X) that is posted to the CWF.			X			X			
5347.8	The carrier shall use MSN message 17.9 ("Medicare Part A pays for this service." The provider must bill the correct Medicare contractor.") when denying a Part B TC or globally billed radiology or physician pathology service with a service date that falls within the admission and discharge dates, inclusive, of a covered hospital inpatient stay posted to the CWF.			X			X			
5347.9	The CWF System Maintainer shall add to the unsolicited process the edit logic for rejecting a Part B TC or globally billed radiology or physician pathology service line item with a service date that falls within the admission and discharge dates, inclusive, on an incoming hospital inpatient bill.								X	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5347.10	The carrier shall adjust a Part B TC or globally billed radiology or physician pathology service line item and recoup the payment when an unsolicited response is received from CWF for a line item with a service date that falls within the admission and discharge dates, inclusive, on an incoming hospital inpatient bill.			X			X			
5347.11	The carrier shall adjust a Part B TC or globally billed physician pathology service line item and recoup the payment when an unsolicited response is received from CWF for a line item with a service date that matches the date of service of a hospital outpatient bill (bill types 13X, 85X).			X			X			
5347.12	The carrier shall use Remittance Advice (RA) Adjustment Reason Code 109 ("Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.") when adjusting a Part B TC or globally billed physician pathology service line item with a service date that matches the date of service on a hospital outpatient bill (bill types 13X, 85X) on an unsolicited response received from CWF.			X			X			
5347.13	The carrier shall use MSN message 17.9 ("Medicare Part A pays for this service. The provider must bill the correct Medicare contractor.") when adjusting a Part B TC or globally billed radiology or physician pathology service line item with a service date that falls within the admission and discharge dates, inclusive, on an incoming hospital inpatient bill.			X			X			
5347.14	The carrier shall use MSN message 17.9 ("Medicare Part A pays for this service. The provider must bill the correct Medicare contractor.") when adjusting a Part B TC or globally billed physician pathology service line item with a service date that matches the date of service on a hospital outpatient bill (13X, 85X).			X			X			

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5347.15	The CWF System Maintainer shall create an edit to reject a Part B TC or globally billed radiology or physician pathology service line item received on or after April 1, 2007, with a service date on or after January 1, 2007, that falls outside the occurrence span code 74 (non-covered level of care) from and through dates plus one day on a hospital inpatient bill posted to the CWF.								X	
5347.16	Effective for claims received on or after April 1, 2007, the carrier shall deny an incoming Part B TC or globally billed radiology or physician pathology service line item with a service date that falls outside the occurrence span code 74 (non-covered level of care) from and through dates plus one day on a hospital inpatient bill posted to the CWF.			X			X			
5347.17	The carrier shall use MSN message 17.9 ("Medicare Part A pays for this service. The provider must bill the correct Medicare contractor.") when denying a Part B TC or globally billed radiology or physician pathology service with a date of service that falls outside the occurrence span 74 (non-covered level of care) from and through dates plus one day on a hospital inpatient bill posted to the CWF.			X			X			
5347.18	The CWF System Maintainer shall bypass the edit on a Part B TC or globally billed radiology or physician pathology service line item in the following situations: - the service date on the incoming TC or globally billed radiology/physician pathology line item falls within the occurrence span code 74 (non-covered level of care) from and through dates plus one day on an acute care hospital or CAH bill posted to the CWF. - the TC or globally billed								X	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	radiology/physician pathology service line item is a cancel only claim (Entry Code 3), - the TC or globally billed radiology/physician pathology service line item is an accrete claim (Entry Code 9), - the TC or globally billed radiology/physician pathology service line item has a Payment Process Indicator other than A (allowed), R, or S. - the CWF override code used for bundling is present.									
5347.19	The CWF System Maintainer shall add to the unsolicited process the edit logic for adjusting a TC or globally billed radiology or physician pathology service line item with a service date that falls outside the occurrence span code 74 (non-covered level of care) from and through dates plus one day on an incoming hospital inpatient bill.			X			X			
5347.20	The carrier shall adjust the TC or globally billed radiology or physician pathology service line item and recoup the payment when an unsolicited response is received from CWF for a line item with a service date that falls outside the occurrence span code 74 (non-covered level of care) from and through dates plus one day on an incoming hospital inpatient bill.			X			X			
5347.21	The carrier shall use Remittance Advice (RA) Adjustment Reason Code 109 ("Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.") when a adjusting a TC or globally billed radiology or physician pathology service line item with a service date that falls outside the occurrence span code 74 (non-covered level of care) from and through dates plus one day on an incoming hospital inpatient bill.			X			X			

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5347.22	The carrier shall use MSN message 17.9 ("Medicare Part A pays for this service. The provider must bill the correct Medicare contractor.") when adjusting a Part B TC or globally billed radiology or physician pathology service line item with a service date that falls outside the occurrence span code 74 (non-covered level of care) from and through dates plus one day on an incoming hospital inpatient bill.			X			X			
5347.23	Carriers should not search their files to either retract payment or retroactively pay claims.			X						
5347.24	Carriers shall adjust claims if they are brought to their attention.			X						
5347.25	Carriers and standard systems shall implement an automated resolution process for CWF rejects, paying those services correctly billed and denying those services on the claim incorrectly billed.			X			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	
5347.26	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	X		X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	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.									

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*: April 1, 2007 **Implementation Date:** April 2, 2007	**No additional funding will be provided by CMS; contractor activities are to be carried out**

Pre-Implementation Contact(s): Joan Proctor-Young (410) 786-0949 or joan.proctoryoung@cms.hhs.gov for Carrier Radiology Services Susan Webster (410) 786-3384 or susan.webster@cms.hhs.gov for Carrier Clinical Laboratory Services Yvette Cousar (410) 786-2160 for Carrier Physician Services or yvette.cousar@cms.hhs.gov Stuart Barranco (410) 786-6152 for FI Claims Processing Issues **Post-Implementation Contact(s):** Your regional office	**within their FY 2007 operating budgets.**

*__Unless otherwise specified, the effective date is the date of service.__

20.2.1 - Hospital and Skilled Nursing Facility (SNF) Patients

(Rev. 1221, Issued: 04-18-07, Effective: 04-01-07, Implementation: 04-02-07)

Carriers may not pay for the technical component (TC) of radiology services furnished to hospital patients. Payment for physicians' radiological services to the hospital, e.g., administrative or supervisory services, and for provider services needed to produce the radiology service, is made by the fiscal intermediary (FI) as a provider service.

FIs include the TC of radiology services for hospital inpatients except Critical Access Hospitals (CAH) in the prospective payment system (PPS) payment to hospitals.

Hospital bundling rules exclude payment to suppliers of the Technical Component (TC) of a radiology service for beneficiaries in a hospital inpatient stay. CWF performs reject edits to incoming claims from suppliers of radiology services.

Upon receipt of a hospital inpatient claim at the CWF, CWF searches paid claim history and compares the period between the hospital inpatient admission and discharge dates to the line item service date on a line item TC of a radiology service billed by a supplier. The CWF will generate an unsolicited response when the line item service date falls within the admission and discharge dates of the hospital inpatient claim.

Upon receipt of an unsolicited response, the carrier will adjust the TC of the radiology service and recoup the payment.

For CAHs, payment is made by the FI based on reasonable cost.

Radiology and other diagnostic services furnished to hospital outpatients are paid under the Outpatient Prospective Payment System (OPPS) to the hospital. This applies to bill types 12X and13Xthat are submitted to the FI. Effective 4/1/06, type of bill 14X is for non-patient laboratory specimens and is no longer applicable for radiology services.

As a result of SNF Consolidated Billing (Section 4432(b) of the Balanced Budget Act (BBA) of 1997), carriers may not pay for the TC of radiology services furnished to Skilled Nursing Facility (SNF) inpatients during a Part A covered stay. The SNF must bill radiology services furnished its inpatients in a Part A covered stay and payment is included in the SNF Prospective Payment System (PPS).

Radiology services furnished to outpatients of SNFs may be billed by the supplier performing the service or by the SNF under arrangements with the supplier. If billed by the SNF, FIs pay according to the Medicare Physician Fee Schedule. SNFs submit claims to the FI with type of bill 22X or 23X.

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

(Rev. 1221, Issued: 04-18-07, Effective: 04-01-07, Implementation: 04-02-07)

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) and Section 104 of the Tax Relief and Health Care Act of 2006, allow the carrier to continue to pay for this service through December 31, 2007.*

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/Tax Relief and Health Care Act of 2006 Section 104,* 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, 2007*.

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 January 1, 2008, 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.