American Clinical Laboratory Association

FREQUENTLY ASKED QUESTIONS ABOUT CHANGES TO THE "TC GRANDFATHER" FOR PHYSICIAN PATHOLOGY SERVICES

We have prepared this memorandum to respond to questions that we have received concerning the current status of the "grandfather" provision, which affects how laboratories bill for the Technical Component (TC) of anatomic pathology services furnished to hospital patients.

> **In sum, as a result of recent Congressional changes, the TC Grandfather Provision will expire on June 30, 2012, and laboratories will no longer be able to bill Medicare for the TC of anatomic pathology services furnished to hospital inpatients and outpatients after that date. As a result, laboratories will be required to bill the hospital for those services.**

What is the Grandfather Provision?

Until 1999, independent clinical laboratories were permitted to bill globally for anatomic pathology services furnished to hospital patients; that is, laboratories could bill the Medicare Part B for both the TC and the Professional Component (PC) of the service. In 1999, however, CMS announced a change in these requirements and stated that it would require laboratories to bill the hospital for the TC of an anatomic pathology service furnished to a hospital inpatient or outpatient. In the Benefits Improvement and Protection Act (BIPA), Congress enacted a special Grandfather Provision that exempted certain hospitals from this requirement, if the hospital had an existing billing arrangement with an independent laboratory. The provision was extended legislatively on several occasions, but is now scheduled to expire on June 30, 2012.

What is the impact of the Grandfather Provision's expiration?

Under Section 3006 of the recently-enacted legislation to extend the payroll tax and adjust the Medicare payment rate for physicians, Congress mandated that the provision expire on June 30, 2012. Therefore, beginning on July 1, 2012, independent laboratories will be required to bill hospitals for the TC of anatomic pathology services furnished to hospital inpatients and outpatients. Independent laboratories will not be permitted to bill Medicare for these services.

Can laboratories decide not to bill hospitals for the TC service?

No. Although it is up to each individual laboratory to determine how to bill the hospital, it would likely raise issues under the federal anti-kickback law and other federal fraud and abuse laws if laboratories provided free TC services to hospitals. The Office of the HHS Inspector General (OIG) has frequently stated that significant questions are raised under the anti-kickback statute, when a provider, such as a laboratory, furnishes free or reduced-price goods or services to an existing or potential referral source, such as a hospital. As a result, laboratories will have to exercise extreme care concerning the terms on which they furnish these services to hospitals, once the Grandfather Provision expires. If the laboratory gave the services away for free or

charged a price that was below fair market value, it could raise issues for both the laboratory and the hospital.

What services are involved in this issue?

This issue concerns the billing and payment for the Technical Component of anatomical pathology services where the services are referred to the independent laboratory by a hospital and the testing services are for inpatient or outpatient hospital services. It does not affect the billing of the Professional Component, (PC); that is, the actual examination and diagnosis of the specimen by the pathologist. The laboratory can continue to bill and collect for those services from Medicare. Further, this discussion does not affect *clinical laboratory* services. In most instances, CMS already requires that clinical laboratory services furnished to hospital patients be billed "under arrangements" to the hospital.

What was the purpose of the "Grandfather Provision?"

Until 1999, an independent laboratory was permitted to bill Medicare directly for the TC of anatomic pathology services furnished to hospital inpatients or outpatients. However, that year, CMS adopted a new policy under which it would only pay the hospital for the TC of pathology services furnished to inpatients and outpatients, even if the services were performed by independent laboratories. Despite the objections of laboratories and hospitals, it was CMS' view that Medicare's payment to the hospital included a payment for the TC of physician pathology services.

Because of concern about the impact of this change on hospitals, especially those in rural and underserved areas, Congress acted to delay the change in CMS policy for certain "covered hospitals." The provision will now expire on June 30, 2012.

What hospitals were covered by the Grandfather Provision?

Section 542 of BIPA stated that Medicare could continue to pay an independent clinical laboratory for the TC of physician pathology services furnished to inpatients and outpatients so long as the hospital referring the services qualified as a "covered hospital." For purposes of Section 542, a covered hospital was one that had an arrangement with an independent laboratory that was in effect as of July 22, 1999 (the date that CMS had first proposed the change in TC billing), under which the laboratory furnished the TC of physician pathology services to fee-for-service Medicare beneficiaries who were hospital inpatients and outpatients and submitted claims for payment for the TC to a Part B carrier.

As a result of this Grandfather Provision, if a "covered hospital" referred anatomic pathology services to an independent laboratory, from a hospital inpatient or outpatient, then the laboratory could continue to bill Medicare directly for the TC of those services, rather than bill the hospital. For hospitals that did not qualify as "covered hospitals," the laboratory was still required to bill the TC to the hospital. The laboratory could always bill the PC of the services directly to Medicare.

What exactly will happen when the provision expires?

For dates of service beginning July 1, 2012 and thereafter, laboratories will be required to bill hospitals for the TC of anatomic pathology services furnished to hospital inpatients and outpatients. Most importantly, laboratories will have no choice but to bill hospitals for the TC of these services. Laboratories and hospitals will also have to determine what steps they need to take to implement this requirement, such as executing new billing agreements.

How will hospitals bill and be paid for these services after the expiration of the Grandfather Provision?

After the expiration of the provision, hospitals will be responsible for obtaining compensation for the TC of a pathology service furnished to inpatients and outpatients. For inpatients, the Medicare payment will be included in the DRG payment received by the hospital; therefore, no additional payment will be made to the hospital for these services. For outpatients, the services will be billed and reimbursed under the Outpatient Prospective Payment System. Payment for these services is included under APCs 0343 or 0344, depending on the type of service provided. Each hospital should discuss how to bill and be paid for these services with its own billing consultants.

We hope you find this information useful. If you have any questions or need any further information, please do not hesitate to contact us.