



Related MLN Matters Article #: MM5813

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Related CR #: 5813

### *2008 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment*

#### Key Words

MM5813, CR5813, R1400CP, Clinical, Laboratory, Schedule

#### Provider Types Affected

Clinical laboratories billing Medicare Carriers, Fiscal Intermediaries (FIs), or Part A/B Medicare Administrative Contractors (A/B MACs)

#### Key Points

- The effective date of the instruction is January 1, 2008.
- The implementation date is January 7, 2008.
- MLN Matters article MM5813 and related Change request (CR) 5813 contain important information regarding:
  - The 2008 annual updates to the clinical laboratory fee schedule;
  - Mapping for new codes for clinical laboratory tests; and
  - Laboratory costs related to services subject to reasonable charge payments.

#### Updates to Fees

- In accordance with Section 1833(h)(2)(A)(i) of the Social Security Act (the Act), as amended by Section 628 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the annual update to the local clinical laboratory fees for 2008 is 0 percent.
- Payment for a clinical laboratory test is the lesser of the actual charge billed for the test, the local fee, or the national limitation amount (NLA). For a cervical or vaginal smear test (pap smear), Section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount.
- The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

## National Minimum Payment Amounts

- The 2008 national minimum payment amount is \$14.76 (\$14.76 plus 0 percent update for 2008). The affected codes for the national minimum payment amount are included in a table on page 2 of MM5813.

## NLA - Maximum

- For tests for which NLAs were established before January 1, 2001, the NLA is 74 percent of the median of the local fees.
- For tests for which NLAs are first established on or after January 1, 2001, the NLA is 100 percent of the median of the local fees in accordance with §1833(h)(4)(B)(viii) of the Act.

## Access to 2008 Clinical Laboratory Fee Schedule

- Internet access to the 2008 clinical laboratory fee schedule data file should be available after November 16, 2007, at <http://www.cms.hhs.gov/ClinicalLabFeeSched> on the Centers for Medicare & Medicaid Services (CMS) website.
- Medicaid state agencies, the Indian Health Service, the United Mine Workers, Railroad Retirement Board, and other interested parties should use the Internet to retrieve the 2008 clinical laboratory fee schedule. It will be available in multiple formats: Excel, text, and comma delimited.

## Public Comments

- On July 16, 2007, CMS hosted a public meeting to solicit input on the payment relationship between 2007 codes and new 2008 Current Procedural Terminology (CPT) codes. Notice of the meeting was published in the Federal Register on May 25, 2007, and on the CMS website on June 18, 2007.
- Recommendations were received from many attendees, including individuals representing laboratories, manufacturers, and medical societies. CMS posted a summary of the meeting and the tentative payment determinations at <http://www.cms.hhs.gov/ClinicalLabFeeSched> on the CMS website. Additional written comments from the public were accepted until October 5, 2007.
- Comments after the release of the 2008 laboratory fee schedule can be submitted to the following address so that CMS may consider them for the development of the 2009 laboratory fee schedule.
- A comment should be in written format and include clinical, coding, and costing information. To make it possible for CMS and its contractors to meet a January 3, 2009, implementation date, comments must be submitted before August 1, 2008.

Centers for Medicare & Medicaid Services (CMS)  
Center for Medicare Management  
Division of Ambulatory Services  
Mailstop: C4-02-14  
7500 Security Boulevard  
Baltimore, Maryland 21244-1850

### Additional Pricing Information

- The 2008 laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615).
- For dates of service January 1, 2008, through December 31, 2008, the fee for clinical laboratory travel code P9603 is \$0.935 per mile and for code P9604 is \$9.35 per flat rate trip basis.
- The clinical laboratory travel codes are billable only for traveling to perform a specimen collection for either a nursing home or homebound patient. If there is a revision to the standard mileage rate for calendar year 2008, CMS will issue a separate instruction on the clinical laboratory travel fees.
- The 2008 laboratory fee schedule also includes codes that have a 'QW' modifier to both identify codes and determine payment for tests performed by a laboratory registered with only a certificate of waiver under the Clinical Laboratory Improvement Amendments.

### Organ or Disease Oriented Panel Codes

- Similar to prior years, the 2008 pricing amounts for certain organ or disease panel codes and evocative/suppression test codes were derived by summing the lower of the fee schedule amount or the NLA for each individual test code included in the panel code.
- The CPT Editorial Panel has created code 80047 (Basic Metabolic Panel (Calcium, ionized)), which is an automated multi-channel chemistry (AMCC) code. New code 80047 is not a replacement for code 80048 (Basic metabolic panel).
- Code 80047 is comprised of eight component test codes, as follows:
  - Calcium, ionized (82330);
  - Carbon Dioxide (82374);
  - Chloride (82435);
  - Creatinine (82565);
  - Glucose (82947);
  - Potassium (84132);
  - Sodium (84295); and
  - Urea Nitrogen (BUN) (84520).

**Note:** Code 80047 cannot be billed for services ordered through an end-stage renal disease (ESRD) facility. All tests billed for services ordered through an ESRD facility must be billed individually, not in an organ disease panel.

### Mapping Information

- CMS advises the following:
  - New code 80047 is priced at the same rate as 80048 with final payment determined by the AMCC Panel Payment Algorithm;

- New code 82310QW is priced at the same rate as 82310;
- New code 82565QW is priced at the same rate as 82565;
- New code 82610 is priced at the same rate as 83883;
- New code 83655QW is priced at the same rate as 83655;
- New code 83993 is priced at the same rate as 83631;
- New code 84704 is priced at the same rate as 84702;
- New code 86356 is priced at the same rate as 86361;
- New code 87500 is priced at the same rate as 87641;
- New code 87809 is priced at the same rate as 87802;
- New code 89321QW is priced at the same rate as 89321;
- New code 89322 is priced at the sum of the rates of 89320 and 85007;
- New code 89331 is priced at the sum of the rates of 89320 and 87015; and
- New AMCC code ATP23 is priced at the same rate as ATP22.

#### Laboratory Costs Subject to Reasonable Charge Payment in 2008

- For outpatients, the codes in the tables starting on page 5 of MM5813 are paid under a reasonable charge basis. These codes include the following categories:
  - Blood products;
  - Transfusion medicine; and
  - Reproductive medicine procedures.
- In accordance with 42 Code of Federal Regulations (CFR) 405.502 – 405.508, the reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update.
- The inflation-indexed update is calculated using the change in the applicable Consumer Price Index for the 12-month period ending June 30 of each year as prescribed by §1842(b)(3) of the Act and 42 CFR 405.509(b)(1).
- The inflation-indexed update for year 2008 is 2.7 percent.
- Manual instructions for determining the reasonable charge payment can be found in the *Medicare Claims Processing Manual*, Chapter 23, Section 80-80.8.
- If there is insufficient charge data for a code, the instructions permit considering charges for other similar services and price lists. The *Medicare Claims Processing Manual* is located at <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage> on the CMS website.
- When these services are performed for independent dialysis facility patients, the *Medicare Claims Processing Manual*, Chapter 8, Section 60.3 instructs that the reasonable charge basis applies.

- However, when these services are performed for hospital based renal dialysis facility patients, payment is made on a reasonable cost basis. When these services are performed for hospital outpatients, payment is made under the hospital outpatient prospective payment system.

**Note:** Biologic products not paid on a cost or prospective payment basis are paid based on §1842(o) of the Act. The payment limits based on section 1842(o), including the payment limits for codes P9041, P9043, P9045, P9046, P9047, and P9048 should be obtained from the Medicare Part B Drug Pricing Files.

## Important Links

The related MLN Matters article can be found at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5813.pdf> on the CMS website.

The official instruction (CR5813) regarding this change may be viewed at

<http://www.cms.gov/Transmittals/downloads/R1400CP.pdf> on the CMS website.

Instruction for calculating reasonable charges are located in the *Medicare Claims Processing Manual*, Chapter 23, Section 80-80.8 at <http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf> on the CMS website.

If providers have questions regarding this issue, they may contact their Medicare Carrier, FI or A/B MAC at their toll-free number, which may be found at

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.