



## Provider Inquiry Assistance

### Calendar Year (CY) 2010 Annual Update for Clinical Laboratory Fee Schedule (CLFS) and Laboratory Services Subject to Reasonable Charge Payment – JA6657

Related CR Release Date: December 23, 2009

Date Job Aid Revised: January 20, 2010

Effective Date: January 1, 2010

Implementation Date: January 4, 2010

**Key Words** MM6657, CR6657, R1884CP, Clinical, Laboratory, Fee Schedule

**Contractors Affected**

- Medicare Carriers
- Fiscal Intermediaries (FIs)
- Part A/B Medicare Administrative Contractors (A/B MACs)

**Provider Types Affected** Provider types affected are clinical laboratories billing Medicare Carriers, FIs, or A/B MACs.



- Change Request (CR) 6657 provides instructions for the CY 2010 CLFS, mapping for new codes for clinical laboratory tests, and updates for laboratory costs subject to the reasonable charge payment.
- There is a related MLN Matters® article that provides additional information on the CLFS at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE1001.pdf> on the CMS website.

**Note:** The Part B deductible and coinsurance do not apply for services paid under the CLFS.

#### National Minimum Payment Amounts

**Provider Needs to Know...**

- For a cervical or vaginal smear test (pap smear), Medicare payment is the lesser of the local fee or the national limitation amount (NLA), but not less than a national minimum payment amount.
- Payment may not exceed the actual charge.
- The CY 2010 national minimum payment amount is \$15.13 (\$15.42 plus (-1.9) percent update for CY 2010).

- The affected codes for the national minimum payment amount are 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88164, 88165, 88166, 88167, 88174, 88175, G0123, G0143, G0144, G0145, G0147, G0148, and P3000.

#### National Limitation Amounts (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 the 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 Section 1833(h)(4)(B)(viii) of the Social Security Act (the Act).

#### Public Comments

- On July 14, 2009, CMS hosted a public meeting to solicit input on the payment relationship between CY 2009 codes and new CY 2010 Current Procedural Terminology codes.
- Notice of the meeting was published in the Federal Register on May 22, 2009, and on the CMS website on approximately June 15, 2009.
- 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 September 18, 2009.
- CMS has also posted a summary of the public comments and the rationale for their final payment determinations on the CMS website.

#### Pricing Information

- The CY 2010 CLFS includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615). The fees have been established in accordance with Section 1833(h)(4)(B) of the Act.
- For dates of service from January 1, 2010, through December 31, 2010, the fee for clinical laboratory travel code P9603 is \$1.00 per mile. The fee for clinical laboratory travel code P9604 is \$10.00 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 CY 2010, CMS will issue a separate instruction on the clinical laboratory travel fees.
- The CY 2010 clinical 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 CY 2010 pricing amounts for certain organ or disease panel codes and evocative/suppression test codes were derived by summing the lower of the CLFS amount or the NLA for each individual test code included in the panel code.

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**Mapping Information**

- New code 83987 is priced at the sum of the rates of codes 82800 and 87015.
- New code 84145 is priced at the same rate as code 84146.
- New code 84431 is priced at the same rate as code 83520.
- New code 86305 is priced at the same rate as code 86316.
- New code 86352 is priced at the sum of the rates of codes 86353 and 82397.
- New code 86780 is priced at the same rate as code 86781.
- New code 86825 is priced at three times the rate of code 86356.
- New code 86826 is priced at the same rate as code 86356.
- New code 87150 is priced at the same rate as code 87798.
- New code 87153 is priced at the sum of the rates of codes 83891, 83898, 83904, 83912, and half of code 87900.
- New code 87493 is priced at the same rate as code 87798.
- New code 88738 is priced at the same rate as code 88740.
- New code 80069QW is priced at the same rate as code 80069 beginning 12/4/2008.
- New code 82040QW is priced at the same rate as code 82040 beginning January 1, 2009.
- New code 82043QW is priced at the same rate as code 82043 beginning October 1, 2009.
- New code 82550QW is priced at the same rate as code 82550 beginning December 4, 2008.
- New code 87905QW is priced at the same rate at code 87905 beginning January 1, 2009.
- Code 83876 is priced at the same rate as code 83880.
- Healthcare Common Procedure Coding System (HCPCS) code G0430 is priced at the same rate as code 80100.
- HCPCS code G0431 is priced at the same rate as code 80101.
- Code 82307 is deleted beginning January 1, 2010.
- Code 82042QW is deleted beginning July 1, 2009.
- Code 83520QW is deleted beginning October 1, 2009.
- Code 86781 is deleted beginning January 1, 2010.
- For CY 2010, there are no new test codes to be gap filled.

**Special Information Regarding Codes G0430, G0431, 80100, and 80101**

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- The special edition MLN Matters® article regarding the use of these four codes is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE1001.pdf> on the CMS website.
- Clinical laboratories billing these codes should review this special edition article for important information regarding the billing of these codes, especially for services from January 1, 2010, through March 31, 2010, inclusive.

**Laboratory Costs Subject to Reasonable Charge Payment in CY 2010**

- For outpatients, the codes in the following table are paid under a reasonable charge basis.
- In accordance with 42 Code of Federal Regulations (CFR) 405.502 through 42 CFR 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 Section 1842(b)(3) of the Act and 42 CFR 405.509(b)(1).
- The inflation-indexed update for CY 2010 is 0 percent.
- Manual instructions for determining the reasonable charge payment can be found in the *Medicare Claims Processing Manual*, Chapter 23, Section 80 through 80.8, which is available at <http://www.cms.hhs.gov/manuals/IOM/list.asp> on the CMS website.
- If there is insufficient charge data for a code, the instructions permit considering charges for other similar services and price lists.
- 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.
- 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.

Blood Products					
P9010	P9011	P9012	P9016	P9017	P9019
P9020	P9021	P9022	P9023	P9031	P9032
P9033	P9034	P9035	P9036	P9037	P9038
P9039	P9040	P9044	P9050	P9051	P9052
P9053	P9054	P9055	P9056	P9057	P9058
P9059			P9060		

- The codes in the following table should be applied to the blood deductible as instructed in the *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 3, Section 20.5 through 20.54.

P9010	P9016	P9021	P9022	P9038	P9039
P9040	P9051	P9054	P9056	P9057	P9058

- Biologic products not paid on a cost or prospective payment basis are paid based on Section 1842(o) of the Act. The payment limits based on Section 1842(o), including the payment limits for codes P9041, P9043, P9045, P9046, P9047, P9048, should be obtained from the Medicare Part B drug pricing files.

Transfusion Medicine					
86850	86860	86870	86880	86885	86886
86890	86891	86900	86901	86903	86904
86905	86906	86920	86921	86922	86923
86927	86930	86931	86932	86945	86950
86960	86965	86970	86971	86972	86975
86976	86977	86978	86985		

Reproductive Medicine Procedures					
89250	89251	89253	89254	89255	89257
89258	89259	89260	89261	89264	89268
89272	89280	89281	89290	89291	89335
89342	89343	89344	89346	89352	89353
89354			89356		

**Update to Fees**

- In accordance with Section 1833(h)(2)(A)(i) of 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 CY 2010 is (-1.4) percent. (The relevant section of the Act is available at [http://www.ssa.gov/OP\\_Home/ssact/title18/1833.htm](http://www.ssa.gov/OP_Home/ssact/title18/1833.htm) on the Internet.)

**Background**

- Section 145 of the Medicare Improvements for Patients and Providers Act of 2008 adjusted the annual update by -0.5 percent through CY 2013. Therefore, the annual update for CY 2010 is (-1.9) percent.
- The annual update to payments made on a reasonable charge basis for all other laboratory services for CY 2010 is 0 percent (See 42 CFR 405.509(b)(1)).
- Section 1833(a)(1)(D) of the Act provides that payment for a clinical laboratory test is the lesser of the actual charge billed for the test, the local fee, or the NLA.

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- 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 (described above).
  - However, for a cervical or vaginal smear test (pap smear), payment may also not exceed the actual charge.
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Impact

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Reference  
Materials

The related MLN Matters® article can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6657.pdf> on the CMS website.

The official instruction (CR6657) issued regarding this change may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R1884CP.pdf> on the CMS website.

Internet access to the CY 2010 clinical laboratory fee schedule data file is available at <http://www.cms.hhs.gov/ClinicalLabFeeSched> on the CMS website. It will be available in multiple formats: Excel, text, and comma delimited.

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