

## **Information Regarding the Final CY 2018 Private Payor Rate-Based Clinical Laboratory Fee Schedule (CLFS) Payment Rates**

### **Background:**

Section 216(a) of the Protecting Access to Medicare Act of 2014 (PAMA) added section 1834A of the Social Security Act (the Act) which significantly revises the Medicare payment methodology for certain clinical diagnostic laboratory tests paid under the Clinical Laboratory Fee Schedule (CLFS). Beginning on January 1, 2018, Medicare will use certain private payor rate information reported by applicable laboratories to calculate Medicare payment rates for most laboratory tests paid under the CLFS. The use of market data to establish CLFS payment rates will strengthen Medicare by paying more appropriately for laboratory services and is expected to save the Medicare program and taxpayers money while maintaining beneficiaries' access to high quality laboratory services.

On September 22, 2017, CMS published the preliminary calendar year (CY) 2018 CLFS payment rates and crosswalking and gapfilling payment method determinations. CMS requested public feedback on the accuracy of the preliminary determinations until October 23, 2017. CMS received over 6,000 comments. Issues related to the calculation of the weighted median and the final private payor rate-based CLFS payment rates are discussed in this document. This document also contains a high level summary of the types of comments CMS received during the comment period and our responses to those comments. The final crosswalking and gapfilling determinations, including public and advisory panel recommendations, are posted on CMS's web site at: [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Laboratory\\_Public\\_Meetings.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Laboratory_Public_Meetings.html).

CMS is finalizing the CY 2018 Medicare CLFS payment rates and crosswalking and gapfilling payment method determinations, which will be implemented on January 1, 2018.

### **Laboratory HCPCS Codes with Revised Final CY 2018 Private Payor Rate-Based CLFS Payment Rates**

After reviewing the public comments, we have revised the CY 2018 private payor rate-based CLFS payment rates in five specific areas as described below:

1. Application of phase-in reduction cap when National Limitation Amount (NLA) is \$0 but some local fee schedule amounts are greater than \$0. Under the CLFS in effect until January 1, 2018, the NLA for a laboratory HCPCS code is based on a percentage of the median of all the local fee schedule amounts (or 100 percent of the median for new tests furnished on or after January 1, 2001). Values of \$0 are included in the median calculation. Medicare pays the lesser of the billed amount, the local fee schedule amount, or the NLA; in practice, most tests are paid at the NLA. Under the new CLFS payment system, a phase-in reduction cap is applied when the weighted median of the private payor rates compared to the 2017 NLA would reduce the payment for the laboratory test by greater than 10%. There are 23 HCPCS codes on the CY 2017 CLFS that have an NLA equal to \$0, despite having some local fee

schedule amounts that are greater than \$0. In the preliminary determinations, these codes were assigned the full payment reduction in CY 2018 rather than the 10% reduction cap. In the final determinations, we recalculated the NLA for these codes by excluding local fee schedule amounts of \$0 so that the NLA would be greater than \$0 for purposes of applying the phase-in reduction cap. For 16 of the codes, the 10 percent phase-in reduction cap is applied to the weighted median of private payor rates. *(See Table A below.)*

2. Payment floor for diagnostic or screening pap smear laboratory tests. CMS received several comments regarding the statutory requirement under Section 1833(h)(7) of the Act that establishes a national minimum payment rate for diagnostic and screening pap smears. Specifically, section 1833(h)(7) requires the Secretary to establish a national minimum payment amount for a diagnostic or screening pap smear laboratory test (including all cervical cancer screening technologies that have been approved by the Food and Drug Administration (FDA) as a primary screening method for detection of cervical cancer) equal to \$14.60 for tests furnished in 2000. The national minimum payment amount for subsequent years is adjusted annually as provided in section 1833(h)(2) of the Act. The CY 2017 floor for these tests was \$14.49. The CY 2018 update factor is 1.1 percent, which yields a CY 2018 floor of \$14.65.

There are 24 diagnostic or screening pap smear laboratory HCPCS codes for CY 2018. CMS did not apply the national minimum payment amount floor for these tests in the preliminary determinations. However, in the final determinations, the national minimum payment amount floor is applied to 8 of these codes. The remaining codes will be paid the higher private payor rate-based payments, with the phase-in reduction cap where applicable. *(See Table B below.)*

3. Payment for home use hemoglobin A1c (HbA1c) kits. CMS also heard from several commenters that CMS did not apply the payment rate set in statute under Section 1833(h)(9) of the Act for home use hemoglobin A1c (HbA1c) kits. Section 1833(h)(9) requires that the payment rate for any diagnostic laboratory test for HbA1c that is labeled by the FDA for home use and is furnished on or after April 1, 2008, must be equal to the payment rate for a glycosylated hemoglobin test identified by HCPCS code 83036 (and any succeeding codes). HCPCS code 83037 is a home use test. We did not apply this provision to HCPCS code 83037 in the preliminary determinations. However, in the final determinations, we reduced the CY 2018 payment rate for HCPCS code 83037 from the proposed rate of \$22.50 to \$11.99, which is the CY 2018 private payor rate-based CLFS payment amount (with the phase-in reduction cap) for code 83036. *(See Table C below.)*
4. Codes with errors in the CY 2019 and CY 2020 payment rates. Commenters identified 23 HCPCS codes for which the preliminary CLFS payment rates with the phase-in reduction cap were listed erroneously (due to transcription errors) for either CY 2019 or CY 2020. The payment rates for these codes are corrected in the final determinations. *(See Table D below.)*

5. HCPCS code 80050 (general health panel) is not payable under Medicare. Commenters noted that HCPCS code 80050 is a bundled code that includes a comprehensive metabolic panel (HCPCS code 80053), thyroid stimulating hormone test (HCPCS code 84443), and a complete blood count (HCPCS code 85025). HCPCS code 80050 previously was not used on Medicare claims and was not listed on the CLFS. While this code was included in the preliminary determinations, CMS has deleted this code from the final CY 2018 CLFS as it is not payable under Medicare.

### **Additional Clarifications Regarding the Weighted Median Calculation and Private Payor Rate-Based CLFS Payment Rates**

In addition to posting the preliminary CLFS payment rates for CY 2018 in September 2017, CMS posted a file that summarized data reporting, how CMS used the data to calculate the preliminary rates, and key findings ([CY 2018 - Summary of Data Reporting for the CLFS Private Payor Rate-Based Payment System \[PDF, 153KB\]](#)). The following are additional questions and comments received during the public comment period following the September postings and CMS's responses.

*Q1. Why did CMS not remove private payor rates with extreme values, from the calculation of the weighted median of the private payor rates (for example \$0.01 and \$99,999 for a single test)?*

A1. It is important to note that CMS relies on laboratories' self-attestation of the completeness and accuracy of their data. Section 414.504(d) of the CLFS regulations requires that the president, chief executive officer, or chief financial officer of a reporting entity, or an individual who has been delegated authority to sign for and reports directly to such an officer, must certify the accuracy and completeness of the applicable information reported to CMS.

With the exception of CMS removing the entire sets of data submitted by 4 reporting entities (discussed in Q&A # 3 below), all applicable information was included in the calculation of the weighted median of private payor rates. Given that the payment amount under the new private payor rate-based CLFS reflects the weighted median of private payor rates reported for a given HCPCS code (and not an average or mean of private payor rates), these outliers generally have little to no effect on the CY 2018 payment rates. For example, in our analysis of 9 HCPCS codes identified by commenters (82731, 87491, 87624, 87653, 87798, 88175, 81207, 81445, and 87633), we found that the volume associated with the extreme outliers was low relative to the total volume associated with the HCPCS code and, as a result, had no impact on the weighted medians. In addition, for these codes, we found that if we had removed values from the weighted median calculation that were 10 times greater and 10 times lesser than the 2017 NLA, the effect on the weighted medians would still be generally minimal to null.

*Q2. In reviewing the raw data file, we noticed that a price of \$0.00 was reported for 2.4 million tests. Did CMS include these "zero" dollar values when determining the weighted median of private payor rates?*

A2. Applicable information is what we use to calculate a weighted median. Applicable

information must include the private payor rate for each test for which final payment has been made during the data collection period, the associated volume for each test, and the specific HCPCS code associated with the test. We excluded “zero” values when determining the weighted median of private payor rates. That is, for determining the payment amount for a given HCPCS code, when the reported private payor rate was “zero” dollars or the associated volume of tests performed corresponding to a given private payor rate was zero, we omitted that record from the calculation of the weighted median of private payor rates.

*Q3. Were there any other circumstances in which CMS excluded data from the calculation of the weighted median of private payor rates?*

A3. As discussed in the September summary on data reporting, we excluded the data submitted by 4 reporting entities because the data showed a pattern of reporting that was clearly not applicable information. Specifically, the data appeared to represent aggregate-level payment information, that is, the total payments for a HCPCS code, instead of each private payor rate for each HCPCS code and the associated volume of tests performed corresponding to each private payor rate. We contacted the 4 reporting entities and received corrected applicable information from 2 of them and included their corrected data in the preliminary and final weighted median calculations. Had CMS included the original aberrant submissions in the weighted median calculations, several of the HCPCS codes would have been assigned inaccurate and inappropriate payment rates. For example, one HCPCS code would have had a payment rate of \$34,993, 42,637% greater than the 2017 NLA; another HCPCS code would have had a payment rate of \$40,016, 41,792% greater than the NLA.

*Q4. How will CMS determine the price of automated testing profiles (ATPs) under the private payor rate-based CLFS payment system?*

A4. For CY 2018, payment for tests that were bundled into ATPs will instead be made at the individual HCPCS code level. In other words, we will pay for each appropriately billed HCPCS code based on the CLFS amount for the specific code billed by the laboratory. Moving forward we will continue to consider the efficiencies of ATPs and the appropriate payment methods for these tests under the new private payor rate-based CLFS. Medicare administrative contractors will continue to apply editing to ensure that if a laboratory panel HCPCS code is submitted and is payable, an individual laboratory HCPCS code that is part of the same panel is not also paid separately.

#### **Additional Comments**

Many of the comments received did not provide specific feedback on the accuracy of the preliminary CLFS rates for CY 2018. For example, some commenters recommended that CMS delay implementation of the new CLFS payment system while other commenters recommended that CMS redefine the term “applicable laboratory” to include hospitals, specifically to ensure hospital outreach laboratory data is included in the calculation of the new CLFS rates. The definition of applicable laboratory was finalized through notice and comment rulemaking. We note that a hospital outreach laboratory, that is, a hospital based laboratory that furnishes laboratory tests to patients other than inpatients or outpatients of the hospital, could be an applicable laboratory if it meets the definition of an applicable laboratory in 42 CFR 414.502.

Several commenters requested that CMS independently verify the data submitted by reporting entities and that the laboratories that reported applicable information met the definition of applicable laboratory. A commenter noted that the existence of outliers in the data indicates flaws in the reporting methodology and the underlying data that may be indicative of broader issues with the system. CMS relies on the laboratories' self-attestation. Section 414.504(d) of the CLFS regulations requires that the president, chief executive officer, or chief financial officer of a reporting entity or an individual who has been delegated authority to sign for such an officer, must certify the accuracy and completeness of the applicable information reported to CMS. Commenters also said that the data collected was not representative of the overall laboratory marketplace. However, the data reported to CMS captures over 96% of laboratory tests on the CLFS, representing over 96% of Medicare's spending on CLFS tests in Calendar Year 2016. Laboratories from every state, the District of Columbia, and Puerto Rico reported data. This strong response gives us confidence that the final payment rates accurately capture the rates paid by private payors and allow CMS to utilize the power of the private market to help make sure the CLFS pays accurately for tests.

Commenters requested clarity on the HCPCS codes that laboratories should use for drugs of abuse testing. For CY 2018, laboratories must use HCPCS codes 80305 through 80307 when billing for presumptive drugs of abuse testing and HCPCS codes G0480 through G0483 when billing for definitive drugs of abuse testing. Additional HCPCS codes for drugs of abuse testing are G0659, 0006U, and 0007U.

Commenters recommended that CMS immediately release the application for Advanced Diagnostic Laboratory Test (ADLT) classification and a streamlined designation process to ensure that appropriate tests can be designated as new ADLTs effective January 1, 2018. CMS is working diligently on the application for ADLT classification.

Additionally, in the Medicare Physician Fee Schedule proposed rule for calendar year 2018 (82 FR 34089), CMS solicited comments to better understand applicable laboratories' experiences with the data reporting, data collection, and other compliance requirements for the first data collection and reporting periods under the new CLFS payment system. We believed industry feedback on these issues would help inform us regarding potential refinements to the private payor rate-based CLFS for future data collection and reporting periods. In response to our solicitation, we received approximately 40 comments from individuals, health care providers, corporations, government agencies, and major laboratory organizations. Commenters provided specific recommendations such as improving the accessibility of the CMS data reporting system by removing certain security measures and changing the requirement that applicable laboratories must report data from claims that require manual remittance processes (82 FR 53181). CMS will consider the comments for potential future rulemaking or publication of subregulatory guidance pertaining to the CLFS data collection and reporting periods.

CMS appreciates the stakeholder participation and feedback we have received on the preliminary CLFS rates and looks forward to continuing to hear feedback from the laboratory industry.

**Table A: Application of Phase-In Reduction Cap When NLA is \$0 but Some Locality Rates Are Greater Than \$0**

HCPCS	HCPCS Description	Weighted Median	Preliminary Determinations NLA				Final Determinations NLA			
			2017 NLA	2018 Pay w/ Cap	2019 Pay w/ Cap	2020 Pay w/ Cap	2017 New NLA	New 2018 Pay w/ Cap	New 2019 Pay w/ Cap	New 2020 Pay w/ Cap
80061	Lipid panel	\$11.23	\$0.00	\$11.23	\$11.23	\$11.23	\$18.37	\$16.53	\$14.88	\$13.39
80074	Acute hepatitis panel	\$38.79	\$0.00	\$38.79	\$38.79	\$38.79	\$65.34	\$58.81	\$52.93	\$47.63
80400	Acth stimulation panel	\$28.80	\$0.00	\$28.80	\$28.80	\$28.80	\$44.74	\$40.27	\$36.24	\$32.62
80402	Acth stimulation panel	\$76.16	\$0.00	\$76.16	\$76.16	\$76.16	\$119.28	\$107.35	\$96.62	\$86.96
80406	Acth stimulation panel	\$63.49	\$0.00	\$63.49	\$63.49	\$63.49	\$107.35	\$96.62	\$86.95	\$78.26
80408	Aldosterone suppression eval	\$109.94	\$0.00	\$109.94	\$109.94	\$109.94	\$172.15	\$154.94	\$139.44	\$125.50
80412	Crh stimulation panel	\$801.62	\$0.00	\$801.62	\$801.62	\$801.62	\$452.16	\$801.62	\$801.62	\$801.62
80414	Testosterone response	\$42.26	\$0.00	\$42.26	\$42.26	\$42.26	\$70.83	\$63.75	\$57.37	\$51.64
80415	Estradiol response panel	\$40.60	\$0.00	\$40.60	\$40.60	\$40.60	\$76.66	\$68.99	\$62.09	\$55.89
80416	Renin stimulation panel	\$209.32	\$0.00	\$209.32	\$209.32	\$209.32	\$181.02	\$209.32	\$209.32	\$209.32
80417	Renin stimulation panel	\$38.89	\$0.00	\$38.89	\$38.89	\$38.89	\$60.34	\$54.31	\$48.88	\$43.99
80420	Dexamethasone panel	\$161.88	\$0.00	\$161.88	\$161.88	\$161.88	\$98.83	\$161.88	\$161.88	\$161.88
80422	Glucagon tolerance panel	\$40.94	\$0.00	\$40.94	\$40.94	\$40.94	\$63.20	\$56.88	\$51.19	\$46.07

HCPCS	HCPCS Description	Weighted Median	Preliminary Determinations NLA				Final Determinations NLA			
			2017 NLA	2018 Pay w/ Cap	2019 Pay w/ Cap	2020 Pay w/ Cap	2017 New NLA	New 2018 Pay w/ Cap	New 2019 Pay w/ Cap	New 2020 Pay w/ Cap
80424	Glucagon tolerance panel	\$34.69	\$0.00	\$34.69	\$34.69	\$34.69	\$69.27	\$62.34	\$56.11	\$50.50
80426	Gonadotropin hormone panel	\$133.40	\$0.00	\$133.40	\$133.40	\$133.40	\$203.58	\$183.22	\$164.90	\$148.41
80428	Growth hormone panel	\$59.53	\$0.00	\$59.53	\$59.53	\$59.53	\$91.50	\$82.35	\$74.12	\$66.70
80430	Growth hormone panel	\$129.33	\$0.00	\$129.33	\$129.33	\$129.33	\$107.66	\$129.33	\$129.33	\$129.33
80432	Insulin suppression panel	\$165.61	\$0.00	\$165.61	\$165.61	\$165.61	\$185.32	\$166.79	\$165.61	\$165.61
80434	Insulin tolerance panel	\$285.03	\$0.00	\$285.03	\$285.03	\$285.03	\$138.78	\$285.03	\$285.03	\$285.03
80436	Metyrapone panel	\$69.35	\$0.00	\$69.35	\$69.35	\$69.35	\$125.05	\$112.55	\$101.29	\$91.16
80438	Trh stimulation panel	\$41.59	\$0.00	\$41.59	\$41.59	\$41.59	\$69.15	\$62.24	\$56.01	\$50.41
80439	Trh stimulation panel	\$33.07	\$0.00	\$33.07	\$33.07	\$33.07	\$92.20	\$82.98	\$74.68	\$67.21
G0471	Ven blood coll snf/hha	\$5.00	\$0.00	\$5.00	\$5.00	\$5.00	\$5.00	\$5.00	\$5.00	\$5.00

**Table B: Payment Floor for Diagnostic or Screening Pap Smear Laboratory Tests**

HCPCS	HCPCS Description	2017 National Limit	2017 Floor	2018 Floor (1.1% Increase)	Weighted Median	2018 Payment w/ cap	2019 Payment w/ cap	2020 Payment w/ cap
88142	Cytopath c/v thin layer	\$27.79	\$14.49	\$14.65	\$19.03	\$25.01	\$22.51	\$20.26
88143	Cytopath c/v thin layer redo	\$27.79	\$14.49	\$14.65	\$23.04	\$25.01	\$23.04	\$23.04
88147	Cytopath c/v automated	\$15.61	\$14.49	\$14.65	\$50.56	\$50.56	\$50.56	\$50.56
88148	Cytopath c/v auto rescreen	\$20.84	\$14.49	\$14.65	\$16.00	\$18.76	\$16.88	\$16.00
88150	Cytopath c/v manual	\$14.49	\$14.49	\$14.65	\$14.41	\$14.65	\$14.65	\$14.65
88152	Cytopath c/v auto redo	\$14.49	\$14.49	\$14.65	\$27.64	\$27.64	\$27.64	\$27.64
88153	Cytopath c/v redo	\$14.49	\$14.49	\$14.65	\$24.03	\$24.03	\$24.03	\$24.03
88154	Cytopath c/v select	\$14.49	\$14.49	\$14.65	\$86.80	\$86.80	\$86.80	\$86.80
88155	Cytopath c/v index add-on	\$8.22	\$0.00	\$14.65	\$4.89	\$14.65	\$14.65	\$14.65
88164	Cytopath tbs c/v manual	\$14.49	\$14.49	\$14.65	\$9.41	\$14.65	\$14.65	\$14.65
88165	Cytopath tbs c/v redo	\$14.49	\$14.49	\$14.65	\$42.22	\$42.22	\$42.22	\$42.22
88166	Cytopath tbs c/v auto redo	\$14.49	\$14.49	\$14.65	\$0.00	\$14.65	\$14.65	\$14.65
88167	Cytopath tbs c/v select	\$14.49	\$14.49	\$14.65	\$0.00	\$14.65	\$14.65	\$14.65
88174	Cytopath c/v auto in fluid	\$29.31	\$14.49	\$14.65	\$25.37	\$26.38	\$25.37	\$25.37
88175	Cytopath c/v auto fluid redo	\$36.34	\$14.49	\$14.65	\$26.61	\$32.71	\$29.44	\$26.61
G0123	Screen cerv/vag thin layer	\$27.79	\$14.49	\$14.65	\$19.30	\$25.01	\$22.51	\$20.26
G0143	Scr c/v cyto,thinlayer,rescr	\$27.79	\$14.49	\$14.65	\$27.05	\$27.05	\$27.05	\$27.05
G0144	Scr c/v cyto,thinlayer,rescr	\$29.31	\$14.49	\$14.65	\$43.97	\$43.97	\$43.97	\$43.97
G0145	Scr c/v cyto,thinlayer,rescr	\$36.34	\$14.49	\$14.65	\$25.19	\$32.71	\$29.44	\$26.49
G0147	Scr c/v cyto, automated sys	\$15.61	\$14.49	\$14.65	\$0.00	\$14.65	\$14.65	\$14.65
G0148	Scr c/v cyto, autosys, rescr	\$20.84	\$14.49	\$14.65	\$31.94	\$31.94	\$31.94	\$31.94
P3000	Screen pap by tech w md supv	\$14.49	\$14.49	\$14.65	\$13.96	\$14.65	\$14.65	\$14.65
Q0111	Wet mounts/ w preparations	\$5.86	\$0.00	\$14.65	\$5.81	\$14.65	\$14.65	\$14.65



<b>HCPCS</b>	<b>HCPCS Description</b>	<b>2017 National Limit</b>	<b>2017 Floor</b>	<b>2018 Floor (1.1% Increase)</b>	<b>Weighted Median</b>	<b>2018 Payment w/ cap</b>	<b>2019 Payment w/ cap</b>	<b>2020 Payment w/ cap</b>
Q0115	Post-coital mucous exam	\$13.57	\$0.00	\$14.65	\$25.00	\$25.00	\$25.00	\$25.00

**Table C: Payment for Home Use Hemoglobin A1c (HbA1c) Kits**

<b>HCPCS</b>	<b>HCPCS Description</b>	<b>2017 National Limit</b>	<b>2017 Floor</b>	<b>Weighted Median</b>	<b>Statutory Weighted Median</b>	<b>2018 Payment w/ cap</b>	<b>2019 Payment w/ cap</b>	<b>2020 Payment w/ cap</b>
83036	Glycosylated hemoglobin test	\$13.32	\$0.00	\$8.50	\$8.50	\$11.99	\$10.79	\$9.71
83037	Glycosylated hb home device	\$13.32	\$0.00	\$22.50	\$8.50	\$11.99	\$10.79	\$9.71

**Table D: Codes with Errors in the CY 2019 and CY 2020 Payment Rates**

HCPCS	HCPCS Description	2017 NLA	Weighted Median	2018 Payment w/ Cap	2019 Payment w/ Cap	Corrected 2019 Payment w/ Cap	2020 Payment w/ Cap	Corrected 2020 Payment w/ Cap
82274	Assay test for blood fecal	\$21.82	\$15.92	\$19.64	\$17.67	\$17.67	\$15.91	\$15.92
82696	Assay of etiocholanolone	\$32.35	\$26.24	\$29.12	\$26.20	\$26.24	\$26.24	\$26.24
82810	Blood gases o2 sat only	\$11.97	\$9.77	\$10.77	\$9.70	\$9.77	\$9.77	\$9.77
82985	Assay of glycated protein	\$20.68	\$16.76	\$18.61	\$16.75	\$16.76	\$16.76	\$16.76
83015	Heavy metal qual any anal	\$25.83	\$20.94	\$23.25	\$20.92	\$20.94	\$20.94	\$20.94
83050	Blood methemoglobin assay	\$10.05	\$8.20	\$9.05	\$8.14	\$8.20	\$8.20	\$8.20
83068	Hemoglobin stability screen	\$11.61	\$9.47	\$10.45	\$9.40	\$9.47	\$9.47	\$9.47
83630	Lactoferrin fecal (qual)	\$26.93	\$19.70	\$24.24	\$21.81	\$21.81	\$19.63	\$19.70
84105	Assay of urine phosphorus	\$7.10	\$5.78	\$6.39	\$5.75	\$5.78	\$5.78	\$5.78
84135	Assay of pregnanediol	\$26.25	\$21.27	\$23.63	\$21.26	\$21.27	\$21.27	\$21.27
84138	Assay of pregnanetriol	\$25.97	\$21.05	\$23.37	\$21.04	\$21.05	\$21.05	\$21.05
85347	Coagulation time activated	\$5.84	\$4.28	\$5.26	\$4.73	\$4.73	\$4.26	\$4.28

HCPCS	HCPCS Description	2017 NLA	Weighted Median	2018 Payment w/ Cap	2019 Payment w/ Cap	Corrected 2019 Payment w/ Cap	2020 Payment w/ Cap	Corrected 2020 Payment w/ Cap
85555	Rbc osmotic fragility	\$9.17	\$7.47	\$8.25	\$7.43	\$7.47	\$7.47	\$7.47
87169	Macroscopic exam parasite	\$5.86	\$4.31	\$5.27	\$4.75	\$4.75	\$4.27	\$4.31
87271	Cytomegalovirus dfa	\$16.44	\$13.42	\$14.80	\$13.32	\$13.42	\$13.42	\$13.42
87280	Respiratory syncytial ag if	\$16.44	\$13.42	\$14.80	\$13.32	\$13.42	\$13.42	\$13.42
87290	Varicella zoster ag if	\$16.44	\$13.42	\$14.80	\$13.32	\$13.42	\$13.42	\$13.42
87327	Cryptococcus neoform ag ia	\$16.44	\$13.42	\$14.80	\$13.32	\$13.42	\$13.42	\$13.42
87380	Hepatitis delta ag ia	\$22.51	\$18.36	\$20.26	\$18.23	\$18.36	\$18.36	\$18.36
87526	Hepatitis g dna amp probe	\$48.14	\$39.26	\$43.33	\$38.99	\$39.26	\$39.26	\$39.26
87631	Resp virus 3-5 targets	\$175.98	\$142.63	\$158.38	\$142.54	\$142.63	\$142.63	\$142.63
88175	Cytopath c/v auto fluid redo	\$36.34	\$26.61	\$32.71	\$29.44	\$29.44	\$26.49	\$26.61
88262	Chromosome analysis 15-20	\$170.98	\$125.49	\$153.88	\$138.49	\$138.49	\$124.64	\$125.49