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|---|---|
| NEWS FLASH | Flu Shot Reminder - As a respected source of health care information, patients trust their doctors' recommendations. If you have Medicare patients who haven't yet received their flu shot, help protect them by recommending an annual influenza and a one time pneumococcal vaccination. Medicare provides coverage for flu and pneumococcal vaccines and their administration. – And don't forget to immunize yourself and your staff. **Protect yourself, your patients, and your family and friends.** Get Your Flu Shot. Remember - Influenza vaccination is a covered Part B benefit. Note that influenza vaccine is NOT a Part D covered drug. For more information about Medicare's coverage of adult immunizations and educational resources, go to http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/SE0667.pdf on the CMS website. |

MLN Matters Number: MM5362 | Related Change Request (CR) #:5362

Related CR Release Date: December 8, 2006 | Effective Date: January 1, 2007

Related CR Transmittal #: R1122CP | Implementation Date: January 2, 2007

# 2007 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

Note: This article was updated on June 20, 2013, to reflect current Web addresses. All other information remains unchanged.

## Provider Types Affected

Clinical laboratories billing Medicare carriers, intermediaries, or Part A/B Medicare Administrative Contractors (A/B MACs)

## Provider Action Needed

This article and related CR5362 contain important information regarding:

- The 2007 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.

It is important that affected laboratories understand these changes to ensure correct and accurate payments from Medicare.

## Key Points

### *Update to Fees*

In accordance with §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 (MMA) of 2003, the annual update to the local clinical laboratory fees for 2007 is zero (0) percent.

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 National Limitation Amount (NLA).

The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

### National Minimum Payment Amounts

For a cervical or vaginal smear test (pap smear), §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. Also, payment may not exceed the actual charge.

The 2007 national minimum payment amount is $14.76 ($14.76 plus zero percent update for 2007). The affected codes for the national minimum payment amount include the following Current Procedure Terminology (CPT) codes:

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|---|---|---|---|---|---|---|
| 88142 | 88143 | 88147 | 88148 | 88150 | 88152 | 88153 |
| 88154 | 88164 | 88165 | 88166 | 88167 | 88174 | 88175 |
| G0123 | G0143 | G0144 | G0145 | G0147 | G0148 | 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 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 2007 Clinical Laboratory Fee Schedule

Internet access to the 2007 clinical laboratory fee schedule data file should be available after November 20, 2006, at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html 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 2007 clinical laboratory fee schedule. It will be available in multiple formats: Excel, text, and comma delimited.

### Public Comments

On July 17, 2006, CMS hosted a public meeting to solicit input on the payment relationship between 2006 codes and new 2007 Current Procedural Terminology codes. Notice of the meeting was published in the Federal Register on May 26, 2006 and on the CMS website on June 19, 2006.

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 on the Web site http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.htm/ on the CMS website.
Additional written comments from the public were accepted until September 26, 2006.

### Additional Pricing Information

The 2006 laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615).

For dates of service January 1, 2007 through December 2007, 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. The standard mileage rate for transportation costs was increased by the Federal Government's Treasury Department to 48.5 cents a mile and this amount is incorporated into the fees for travel codes P9603 and P9604.

The 2007 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 (CLIA). Based on comments and data submitted, codes 83037 and 83037QW are priced by crosswalking to code 82985.

### Organ or Disease Oriented Panel Codes

Similar to prior years, the 2006 pricing amounts for certain organ or disease panel codes and evocative/suppression test codes were determined by Medicare by summing the lower of the fee schedule amount or the NLA for each individual test code included in the panel code.

### Mapping Information

CMS advises the following:

- New code 80178QW is priced at the same rate as code 80178.
- New code 82107 is priced at the same rate as code 83950.

- New code 83698 is priced at the same rate as code 83880.
- New code 83913 is priced at the same rate as code 83907.
- New code 84443QW is priced at the same rate as code 84443.
- New code 86788 is priced at the same rate as code 86645.
- New code 86789 is priced at the same rate as code 86644.
- New code 86901 is priced at the same rate as code 86900.
- New code 87305 is priced at the same rate as code 87327.
- New code 87498 is priced at the same rate as code 87496.
- New code 87640 is priced at the same rate as code 87651.
- New code 87641 is priced at the same rate as code 87651.
- New code 87653 is priced at the same rate as code 87651.
- New code 87808 is priced at the same rate as code 87802.
- New code 87808QW is priced at the same rate as code 87808.
- New code G0394 is priced at the same rate as code 82270.

### *Laboratory Costs Subject to Reasonable Charge Payment in 2006*

For outpatients, the following codes are paid under a reasonable charge basis. In accordance with 42 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 2007 is 4.3 percent.

Manual instructions for determining the reasonable charge payment can be found in the *Medicare Claims Processing Manual,* Chapter 23, §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.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html* on the CMS website.

When these services are performed for independent dialysis facility patients, *Medicare Claims Processing Manual,* Chapter 8, §60.3 instructs 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. Also, when these services are performed for hospital outpatients, payment is made under the hospital outpatient prospective payment system (OPPS).

### *Blood Products*

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|---|---|---|---|---|---|---|
| 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 | | | |

Also, the following codes should be applied to the blood deductible, as instructed in the *Medicare General Information, Eligibility and Entitlement Manual*, (also available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html*) Chapter 3, Section 20.5-20.54:

| | | | | | | |
|---|---|---|---|---|---|---|
| P9010 | P9011 | P9016 | P9021 | P9022 | P9038 | P9039 |
| P9040 | P9051 | P9054 | P9056 | P9057 | P9058 | |

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.

### *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 | G0267 |

### *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 | | |

## Additional Information

If you have questions, please contact your Medicare fiscal intermediary (FI), carrier or A/B MAC at their toll-free number which may be found at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

For complete details regarding CR5362, please see the official instruction issued to your Medicare FI, Carrier or A/B MAC. That instruction may be viewed by going to http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1122CP.pdf on the CMS website.

Instructions for calculating reasonable charges are located in the Medicare Claims Processing Manual (Pub. 100-04) Chapter 23, Sections 80-80.8 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf on the CMS website.