Medicare Learning Network
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Information for Medicare Fee-For-Service Health Care Professionals

News Flash – The *General Equivalence Mappings – ICD-9-CM To and From ICD-10-CM and ICD-10-PCS Fact Sheet* (March 2009), which provides information and resources regarding the General Equivalence Mappings that were developed as a tool to assist with the conversion of International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) codes to International Classification of Diseases, 10th Edition (ICD-10) and the conversion of ICD-10 codes back to ICD-9-CM, is now available in downloadable format from the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network at http://www.cms.gov/Medicare/Coding/ICD10/Downloads/GEMs-CrosswalksBasicFAQ.pdf on the CMS website. The fact sheet is also available in print format. To place your order, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html , scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page."

MLN Matters® Number: MM6395 Revised
Related Change Request (CR) #: 6395
Related CR Release Date: July 30, 2009
Effective Date: July 1, 2009
Related CR Transmittal #: R1782CP
Implementation Date: July 6, 2009

Section 148 of The Medicare Improvements for Patients and Providers Act (MIPPA)

Note: This article was updated on December 20, 2012, to reflect current Web addresses. This article was previously revised on July 31, 2009, to reflect that CR 6395 was revised on July 30, 2009. The CR release date and transmittal number (see above) were revised. The Web address for accessing CR 6395 was also revised. All other information remains the same.

Provider Types Affected

Critical Access Hospitals (CAHs) that bill Medicare fiscal intermediaries (FIs) or Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries. Rural health clinics (RHCs), federally qualified health clinics (FQHCs), and skilled nursing facilities (SNFs) may also want to review this article, which clarifies information regarding payment to these entities for laboratory tests performed at an RHC, an FQHC, or a SNF.

What You Need to Know

CR 6395, from which this article is taken, announces a change in the payment methodology for Critical Access Hospitals (CAHs) submitting claims for certain outpatient clinical diagnostic laboratory tests.

As mandated by Section 148 of The Medicare Improvements for Patients and Providers Act (MIPPA), effective for services furnished on or after July 1, 2009, a CAH will be paid 101% of reasonable cost for outpatient clinical diagnostic laboratory tests even if the patient for whom these services are billed was not physically present in the CAH at the time the specimen is collected. In such cases, the CAH will receive 101% of reasonable cost for the outpatient clinical diagnostic laboratory test as long as the patient is an outpatient of the CAH and is receiving services directly from the CAH. For purposes of section 148, the patient is considered to be receiving services directly from the CAH if either one of the following qualifications is met: 1) The patient receives outpatient services in the CAH on the same day the specimen is collected, or 2) The specimen is collected by an employee of the CAH. If the patient is physically present in the CAH or a facility that is provider based to the CAH at the time the specimen is collected, neither of the above two conditions need to be met.

For purposes of payment when a patient is located in a SNF and the CAH employee goes to the SNF to collect a specimen, the CAH will only receive payment at 101% of reasonable cost once the patient's Medicare Part A days have expired. Prior to the patient's Part A days expiring, payment for the collection of a lab specimen at a SNF is included in the SNF's bundled payment.

For non-patients, tests are still to be billed on the Type of Bill (TOB) 14X and such claims will be paid based on the clinical laboratory fee schedule.

You should make sure that your billing staffs are aware of these changes.

Background

CR 3835 (Redefined Type of Bill (TOB), 14x, for Non-Patient Laboratory Specimens, issued on October 28, 2005), introduced a new definition of Type of Bill (TOB) 14X, to be used only for non-patient laboratory specimens, effective October 1, 2004; and also provided that Critical Access Hospitals (CAHs) billing a 14X TOB for a non-patient laboratory specimen would be reimbursed under the Clinical Laboratory Fee Schedule. (You can find the MLN Matters® article related to this CR at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM3835.pdf on the Centers for Medicare & Medicaid Services (CMS) website). Tests for non-patients are still to be billed on the Type of Bill (TOB) 14X and such claims will be paid based on the clinical laboratory fee schedule.

However, CR 6395, from which this article is taken, changes the policy of who is considered an outpatient of a CAH when outpatient clinical diagnostic laboratory services are provided, effective for dates of service on or after July 1, 2009. Section 148 of MIPPA provides that the patient for whom the services are provided is no longer required to be physically present in the CAH at the time the specimen is collected; but must be an outpatient of the CAH (as defined by 42 CFR 410.2) as previously noted. If said outpatient requirements are met, a CAH can submit a 85X Type of Bill for outpatient clinical diagnostic laboratory tests for such patients for dates of service on or after July 1, 2009. Such services will be paid at 101% of reasonable cost.

Note that beneficiaries are not liable for any coinsurance, deductible, co-payment, or other cost sharing amount with respect to CAH clinical laboratory services.

Please be aware that payment to a rural health clinic (RHC)/federally qualified health clinic (FQHC) for laboratory tests performed for a patient of that clinic/center is not included in the all-inclusive rate and may be billed separately by either the base provider for a provider-based RHC/FQHC, or by the physician for an independent or free-standing RHC/FQHC. If the RHC/FQHC is provider-based, payment for laboratory tests is to the base provider (i.e., hospital). If the RHC/FQHC is independent or freestanding, payment for laboratory tests is made to the practitioner (physician) via the clinical laboratory fee schedule.

Additional Information

You can view CR 6395, the official instruction issued to your FI or MAC, at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1782CP.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

The updated Medicare Claims Processing Manual, Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Chapter 13 (Radiology Services and Other Diagnostic Procedures), and Chapter 16 (Laboratory Services), are included as an attachment to CR 6395.

If you have any questions, please contact your FI 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.