



**News Flash** – Revised! The Medicare Learning Network® (MLN) is now offering the “Understanding the Remittance Advice (RA) for Institutional Providers” Web-Based Training (WBT). This WBT is designed to educate all institutional providers who bill Medicare with general RA information. It includes instructions to help you interpret the RA received from Medicare and reconcile it against submitted claims. It also provides guidance on how to read Electronic Remittance Advices and Standard Paper Remittance Advices, as well as information on balancing an RA. This activity offers continuing education and is available from the MLN at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html> by scrolling to the bottom of the page and selecting Web-Based Training Modules from the Related Links Inside the Centers for Medicare & Medicaid Services (CMS) section.

MLN Matters® Number: MM6991 **Revised**

Related Change Request (CR) #: 6991

Related CR Release Date: November 24, 2010

Effective Date: January 1, 2011

Related CR Transmittal #: R2106CP

Implementation Date: January 3, 2011

## **Calendar Year (CY) 2011 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment**

**Note:** This article was updated on December 6, 2012, to reflect current Web addresses. This article was previously revised on December 1, 2010, to correct the annual update percentage shown on page 2 for laboratory tests paid on a reasonable charge basis. All other information is the same.

### **Provider Types Affected**

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

### **Impact on Providers**

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 6991 which provides instructions for the Calendar Year (CY) 2011 clinical laboratory fee schedule, mapping for new codes for clinical laboratory tests, and updates for laboratory costs subject to the reasonable charge payment.

#### **Disclaimer**

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## Background

In accordance with the Social Security Act (Section 1833(h)(2)(A)(i); see [http://www.ssa.gov/OP\\_Home/ssact/title18/1833.htm](http://www.ssa.gov/OP_Home/ssact/title18/1833.htm) on the Internet), and further amended by Section 3401 of the Affordable Care Act, the annual update to the local clinical laboratory fees for CY 2011 is -1.75 percent. The annual update to local clinical laboratory fees for CY 2011 reflects an additional multi-factor productivity adjustment as described by the Affordable Care Act. The annual update to payments made on a reasonable charge basis for all other laboratory services for CY 2011 is 1.1 percent (See 42 CFR 405.509(b)(1)). Section 1833(a)(1)(D) of the Social Security Act (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).

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

**Note:** 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), the Social Security Act (Section 1833(h)(7)) 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 CY 2011 national minimum payment amount is \$14.87 percent (\$15.13 minus the 1.75 percent update for CY 2011). The affected codes for the national minimum payment amount are shown in the following table:

88142	88143	88147	88148	88150	88152
88153	88154	88164	88165	88166	88167
88174	88175	G0123	G0144	G0145	G0147
G0148	P3000				

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### ***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 Act.

### ***Access to Data File***

Internet access to the CY 2011 clinical laboratory fee schedule data file will be available after November 19, 2010, at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html> on the CMS website. Other interested parties, such as the Medicaid State agencies, the Indian Health Service, the United Mine Workers, and the Railroad Retirement Board, should use the Internet to retrieve the CY 2011 clinical laboratory fee schedule. It will be available in multiple formats: Excel, text, and comma delimited.

### ***Public Comments***

On July 22, 2010, CMS hosted a public meeting to solicit input on the payment relationship between CY 2010 codes and new CY 2011 Current Procedural Terminology (CPT) codes. CMS posted a summary of the meeting and the tentative payment determinations at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html> on the CMS website. Additional written comments from the public were accepted until October 29, 2010 and a summary of the public comments and the rationale for the final payment determinations are posted on the same CMS website.

### ***Pricing Information***

The CY 2011 clinical laboratory fee schedule 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.

The fees for clinical laboratory travel codes P9603 and P9604 are updated on an annual 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 2011, CMS will issue a separate instruction on the clinical laboratory travel fees.

The CY 2011 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 having only a certificate of waiver under the Clinical Laboratory Improvement Amendments (CLIA).

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### *Organ or Disease Oriented Panel Codes*

Similar to prior years, the CY 2011 pricing amounts for certain organ or disease panel codes and evocative/suppression test codes were derived by summing the lower of the clinical laboratory fee schedule amount or the NLA for each individual test code included in the panel code. The NLA field on the data file is zero-filled.

### *Mapping Information*

- New code 82930 is priced at the same rate as code 82926.
- New code 83861 is priced at the same rate as code 83909.
- New code 84112 is priced at the same rate as code 82731.
- New code 85598 is priced at the same rate as code 85597.
- New code 86481 is priced at the same rate as code 86480.
- New code 86902 is priced at the same rate as code 86905.
- New code 87501 is priced at the sum of the rates of codes 87521 and 83902.
- New code 87502 is priced at the sum of the rates of codes 87801 and 83902.
- New code 87503 is priced at the sum of the rates of codes 83901 and 83896.
- New code 87906 is priced at half of code 87901.
- Healthcare Common Procedure Coding System (HCPCS) Code G0434 is priced at the same rate as code G0430.
- HCPCS Code G9143 is priced at the sum of the rates of codes 83891, 83900, 83901, 83912, three times the rate of code 83896, and three times the rate of code 83908. A two-character modifier indicates that this test's use is limited to a Coverage with Evidence Development (CED) study.
- HCPCS Code G0432 is priced at the same rate as code 86703.
- HCPCS Code G0433 is priced at the same rate as code 86703.
- HCPCS Code G0435 is priced at the same rate as code 87804.
- Reconsidered code 84145 is priced at the same rate as code 82308.
- Reconsidered code 84431 is priced at the same rate as code 84443.
- Reconsidered code 86352 is priced at twice the sum of the rates of codes 86353 and 82397.
- HCPCS Code G0430 is deleted beginning January 1, 2011.

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- HCPCS Code G0431 is priced at five times the rate of HCPCS Code G0430.
- New Code 84155QW is priced at the same rate as code 84155 beginning January 1, 2010.
- New Code 87809QW is priced at the same rate as code 87809 beginning January 1, 2008.

For CY 2011, there are no new test codes that need to be gap-filled.

### ***Laboratory Costs Subject to Reasonable Charge Payment in CY 2011***

For outpatients, the following codes are paid under a reasonable charge basis (See Section 1842(b)(3) of the Act). In accordance with 42 CFR 405.502 through 42 CFR 405.508, (see

[http://www.access.gpo.gov/nara/cfr/waisidx\\_01/42cfr405\\_01.html](http://www.access.gpo.gov/nara/cfr/waisidx_01/42cfr405_01.html) on the Internet) 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 set forth in 42 CFR 405.509(b)(1)(see [http://www.ssa.gov/OP\\_Home/ssact/title18/1842.htm](http://www.ssa.gov/OP_Home/ssact/title18/1842.htm) on the Internet). The inflation-indexed update for CY 2011 is 1.1 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 (see <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf> on the CMS website). If there is sufficient 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; see <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c08.pdf>) 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. Also, 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

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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 (Chapter 3, Section 20.5 through 20.54; see

<http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage> on the CMS website):

P9010	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 the Social Security Act (Section 1842(o)). The payment limits based on that provision, including the payment limits for codes P9041, P9043, P9046, P9047 and P9048, should be obtained from the Medicare Part B drug pricing files.

<i>Transfusion Medicine</i>					
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		

<i>Reproductive Medicine Procedures</i>					
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				

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## Additional Information

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If you have questions, please contact your Medicare A/B MAC, carrier and/or FI 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. The official instruction associated with this CR6991, issued to your Medicare A/B MAC, and/or FI regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2106CP.pdf> on the CMS website.

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