DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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NEWS FLASH

The "September 2013 ICD-10-CM/PCS Billing and Payment Frequently Asked Questions" Fact Sheet (ICN 908974) was released and is now available in downloadable format. This fact sheet is designed to provide education on the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS). It includes the following information: ICD-10-CM/PCS compliance date and billing and payment Frequently Asked Questions.

MLN Matters® Number: MM8517

Related Change Request (CR) #: CR 8517

Related CR Release Date: November 22, 2013

Effective Date: January 1, 2014

Related CR Transmittal #: R2823CP

Implementation Date: January 6, 2014

Calendar Year (CY) 2014 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

Provider Types Affected

This MLN Matters® Article is intended for clinical diagnostic laboratories who submit claims to Medicare Claims Administration Contractors (carriers, Fiscal Intermediaries (FIs), and/or A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8517 which provides instructions for the Calendar Year (CY) 2014 clinical laboratory fee schedule, mapping for new codes for clinical laboratory tests, and updates for laboratory costs subject to the reasonable charge payment. Be sure that your billing staff is aware of these updates.

Background

Update to Fees

In accordance with the Social Security Act (Section 1833(h)(2)(A)(i)), as amended by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Section 628), and further amended by the Affordable Care Act (Section 3401), the annual update to the local clinical laboratory fees for CY 2014 is (-0.75) percent. The annual update to local clinical laboratory fees for CY 2014 reflects an additional multi-factor productivity adjustment and a (-1.75) percentage point reduction 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 2014 is 1.80 percent (See 42 CFR 405.509(b)(1) at http://www.ecfr.gov/cgi-bin/text-idx?SID=40538fb2e20d60fb4d4de0ab33d0ca22&node=42:2.0.1.2.5&rgn=div5#42:2.0.1.2.5.5.25.10 on the Internet). The Social Security Act Section 1833(a)(1)(D); (see http://www.ssa.gov/OP_Home/ssact/title18/1833.htm) 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), 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 (described below). However, for a cervical or vaginal smear test (pap smear), payment may also not exceed the actual charge. 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 2014 national minimum payment amount is $14.42 ($14.53 plus (-0.75) percent update for CY 2014). 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 the Social Security Act (Section 1833(h)(4)(B)(viii)).

Access to Data File

The CY 2014 clinical laboratory fee schedule data file will be retrieved electronically through Centers for Medicare & Medicaid Services (CMS) mainframe telecommunications system. Carriers will retrieve the data file on or after November 19, 2013. Intermediaries will retrieve the data file on or after November 19, 2013. Internet access to the CY 2014 clinical laboratory fee schedule data file will be

available after November 19, 2013, 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, will use the Internet to retrieve the CY 2014 clinical laboratory fee schedule. It will be available in multiple formats: Excel, text, and comma delimited.

Data File Format

For each test code, if your system retains only the pricing amount, load the data from the field named "60% Pricing Amt." For each test code, if your system has been developed to retain the local fee and the NLA, you may load the data from the fields named "60% Local Fee Amt" and "60% Natl Limit Amt" to determine payment. For test codes for cervical or vaginal smears (pap smears), you should load the data from the field named "60% Pricing Amt" which reflects the lower of the local fee or the NLA, but not less than the national minimum payment amount. Fiscal Intermediaries should use the field "62% Pricing Amt" for payment to qualified laboratories of sole community hospitals.

Public Comments

On July 10, 2013, CMS hosted a public meeting to solicit input on the payment relationship between CY 2013 codes and new CY 2014 CPT codes. Notice of the meeting was published in the Federal Register on May 24, 2013 (see http://www.federalregister.gov/articles/2013/05/24/2013-12225/medicare-program-public-meeting-in-calendar-year-2013-for-new-clinical-laboratory-test-payment), and on the CMS website approximately June 1, 2013. 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 website 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 30, 2013. CMS has posted a summary of the public comments and the rationale for the final payment determinations on the CMS website.

Pricing Information

The CY 2014 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 Social Security 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 2014, CMS will issue a separate instruction on the clinical laboratory travel fees.

The CY 2014 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).

Organ or Disease Oriented Panel Codes

Similar to prior years, the CY 2014 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

Existing code 82777 is priced at the same rate as code 84244.

New code 80155 is priced at the same rate as code 80198.

New code 80159 is priced at the same rate as code 80154.

New code 80169 is priced at the same rate as code 80195.

New code 80171 is priced at the same rate as code 80157.

New code 80175 is priced at the same rate as code 80157.

New code 80177 is priced at the same rate as code 80157.

New code 80180 is priced at the same rate as code 80158.

New code 80183 is priced at the same rate as code 80157.

New code 80199 is priced at the same rate as code 82542.

New code 80203 is priced at the same rate as code 80157.

New code 81161 is to be gap filled.

New code 81287 is to be gap filled.

New code 87661 is priced at the same rate as code 87511.

Laboratory Costs Subject to Reasonable Charge Payment in CY 2011

For outpatients, the following codes are paid under a reasonable charge basis (See the Social Security Act (Section 1842(b)(3)) at http://www.ssa.gov/OP_Home/ssact/title18/1842.htm on the Internet). In accordance with 42 CFR 405.502 through 42 CFR 405.508 (see http://www.ecfr.gov/cgi-bin/text-idx?SID=ab7bf0a61515aca26cefc0f2e7dae3b9&c=ecfr&tpl=/ecfrbrowse/Title42/42cfrv2_02.tpl), 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.ecfr.gov/cgi-bin/text-idx?SID=40538fb2e20d60fb4d4de0ab33d0ca22&node=42:2.0.1.2.5&rgn=div5#42:2.0.1.2.5.5.25.10). The inflation-indexed update for CY 2013 is 1.7 percent.

Manual instructions for determining the reasonable charge payment can be found in Publication 100-4, Medicare Claims Processing Manual, Chapter 23, Section 80 through 80.8 (see http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf). If there is sufficient charge data for a code, the instructions permit considering charges for other similar services and price lists.

When services described by the Healthcare Common Procedure Coding System (HCPCS) in the following list are performed for independent dialysis facility patients, Publication 100-04, 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 (OPPS).

Blood Products

Blood products codes are: 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, and P9060.

Also, payment for the following codes (including Transfusion Medicine, and Reproductive Medicine Procedures, listed below) should be applied to the blood deductible as instructed in the "Medicare General Information, Eligibility, and Entitlement Manual," Chapter 3, Section 20.5 through 20.5.4: P9010, P9016, P9021, P9022, P9038, P9039, P9040, P9051, P9054, P9056, P9057, and 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 the Social Security Act (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

Transfusion Medicine codes are: 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, and 86985.

Reproductive Medicine Procedures

Reproductive Medicine Procedures codes are: 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, and 89356.

MACs will not search their files to either retract payment or retroactively pay claims processed prior to implementation of CR8517; however, they will adjust such claims that you bring to their attention.

Additional Information

You can find the official instruction, CR 8517, issued to your MAC regarding this change at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2823CP.pdf on the CMS website.

If you have any questions, please contact your 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.

News Flash - Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information, visit:

- MLN Matters® Article #MM8433, "Influenza Vaccine Payment Allowances - Annual Update for 2013-2014 Season"
- MLN Matters® Article #SE1336, "2013-2014 Influenza (Flu) Resources for Health Care Professionals"
- HealthMap Vaccine Finder - a free, online service where users can search for locations offering flu and other adult vaccines. While some providers may offer flu vaccines, those that don't can help their patients locate flu vaccines within their local community.

The CDC website for Free Resources, including prescription-style tear-pads that allow you to give a customized flu shot reminder to patients at high-risk for complications from the flu.