

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



News Flash – Remember: Beginning Sunday, January 1, 2012, suppliers who furnish the Technical Component (TC) of Advanced Diagnostic Imaging (ADI) must be accredited to bill Medicare for certain services. MRI, CT, nuclear medicine imaging, and positron emission tomography. X-ray, ultrasound, fluoroscopy, and hospital outpatient procedures are excluded. For Dates of Service on or after Sunday, January 1, 2012, Medicare Administrative Contractors (MACs) will deny claims for the Technical Component of ADI that are submitted under the Physician Fee Schedule by suppliers who have not yet been accredited. For more information, please refer to the <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html> and <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1122.pdf>.

MLN Matters® Number: MM7654 **Revised**

Related Change Request (CR) #: 7654

Related CR Release Date: December 9, 2011

Effective Date: January 1, 2012

Related CR Transmittal #: R2365CP

Implementation Date: January 3, 2012

Calendar Year (CY) 2012 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

Note: This article was updated on August 2, 2012, to reflect current Web addresses. All other information remains the same.

Provider Types Affected

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

What You Need to Know

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The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 7654, which provides instructions to Medicare contractors for the Calendar Year (CY) 2012 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 your staffs are aware of these updates.

Background

Annual Updates to Fees

The annual update to the local clinical laboratory fees for CY 2012 is 0.65 percent. The annual update to local clinical laboratory fees for CY 2012 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 2012 is 3.6 percent (See 42 Code of Federal Regulations (CFR) 405.509(b)(1)).

The Social Security Act (the Act), Section 1833(a)(1)(D) 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. The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

This update is in accordance with Section 1833(h)(2)(A)(i) of the Act, as amended by Section 628 of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, and further amended by Section 3401 of the Affordable Care Act.

National Minimum Payment Amounts

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. Also, payment may not exceed the actual charge. The CY 2012 national minimum payment amount is \$14.97 (\$14.87 plus 0.65 percent update for CY 2012). The affected codes for the national minimum payment amount are shown in the following table:

88142	88143	88147	88148	88150
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88152	88153	88154	88164	88165
88166	88167	88174	88175	G0123
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 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.

Public Comments

On July 18, 2011, CMS hosted a public meeting to solicit input on the payment relationship between CY 2011 codes and new CY 2012 CPT codes. Notice of the meeting was published in the “Federal Register” on February 25, 2011, and on the CMS website on or about June 15, 2011. 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 at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html> at the CMS website. Additional written comments from the public were accepted until October 28, 2011. CMS has posted a summary of the public comments and the rationale for the final payment determinations on the CMS website.

Molecular Pathology Procedure Test Codes

Beginning January 1, 2012, there will be 101 additional Molecular Pathology Procedure test codes released by the American Medical Association. For payment purposes under the Clinical Laboratory Fee Schedule, these test codes will be assigned a “B” indicator – “Payment for covered services are always bundled into payment for other services not specified. There will be no RVUs or payment amounts for these codes and no separate payment is ever made. When these services are covered, payment for them is subsumed by the payment for the services to which they are incident (an example is a telephone call from a hospital nurse regarding care of a patient).”

However, each of these new Molecular Pathology Procedure test codes represents a test that is currently being used and which may be billed to Medicare. When these types of tests are billed to Medicare, CMS understands that existing Current Procedural Terminology (CPT) test codes are “stacked” to represent a given test. For example, Laboratory A has a genetic test that is generally billed to Medicare as follows in order to represent the performance of the entire test:

83891 (one time) + 83898 (multiple times) + 83904 (multiple times) + 83909 (multiple times) + 83912 (one time).

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If the new CPT test coding structure were active, Laboratory A would bill Medicare the new, single CPT test code that corresponds to the test represented by the “stacked” codes in the example above rather than billing each component of the test separately.

As of January 1, 2012, Medicare requests that Medicare claims for Molecular Pathology Procedures reflect both the existing CPT “stacked” test codes that are required for payment and the new single CPT test code that would be used for payment purposes if the new CPT test codes were active.

Referring to the example above, Laboratory A would report the existing stacked set of codes that are required to receive payment, as follows:

83891 (one time) + 83898 (multiple times) + 83904 (multiple times) + 83909 (multiple times) + 83912 (one time) along with the new, single CPT test code that corresponds to the test represented by the “stacked” test codes.

While the allowed charge amount will be \$0.00 for the new Molecular Pathology Procedure test codes that carry the “B” indicator, Medicare requests that Medicare claims also reflect a charge for the non-payable service.

The table below contains the CY 2012 Molecular Pathology Procedure test codes:

81200	81205	81206	81207	81208
81209	81210	81211	81212	81213
81214	81215	81216	81217	81220
81221	81222	81223	81224	81225
81226	81227	81228	81229	81240
81241	81242	81243	81244	81245
81250	81251	81255	81256	81257
81260	81261	81262	81263	81264
81265	81266	81267	81268	81270
81275	81280	81281	81282	81290
81291	81292	81293	81294	81295
81296	81297	81298	81299	81300
81301	81302	81303	81304	81310
81315	81316	81317	81318	81319
81330	81331	81332	81340	81341

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81342	81350	81355	81370	81371
81372	81373	81374	81375	81376
81377	81378	81379	81380	81381
81382	81383	81400	81401	81402
81403	81404	81405	81406	81407
81408				

Access to Data File

Internet access to the CY 2012 Clinical Laboratory Fee Schedule data file will be available after November 21, 2011, 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, may use the Internet to retrieve the CY 2012 Clinical Laboratory Fee Schedule, which will be available in multiple formats: Excel, text, and comma delimited.

Pricing Information

The CY 2012 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 annually. 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 2012, CMS will issue a separate instruction on the clinical laboratory travel fees.

The CY 2012 Clinical Laboratory Fee Schedule also includes codes that have a “QW” modifier, defined as CLIA Waived Test, 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

As in to prior years, the CY 2012 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 86386 is priced at the same rate as code 82487.

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- New code 87389 is priced at the same rate as code 86703 plus 50% of code 87390.
- Reconsidered code G0434 is priced at the same rate as code G0430.
- Reconsidered code G0435 is priced at the same rate as code 87804.
- Reconsidered code 83861 is priced at the same rate as code 84081.
- Reconsidered code 87906 is priced at the same rate as 50% of code 87901.
- Reconsidered code 86481 is priced at the same rate as code 86480 plus code 83520.
- For CY 2012, 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. 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). The inflation-indexed update for CY 2012 is 3.6 percent.

Manual instructions for determining the reasonable charge payment can be found in the "Medicare Claims Processing Manual", Chapter 23, Sections 80 through 80.8. If there is sufficient charge data for a code, the instructions permit considering charges for other similar services and price lists. Note: The Medicare manuals noted in this article are available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html> on the CMS website.

When services described by the Healthcare Common Procedure Coding System (HCPCS) in the following list are performed for independent dialysis facility patients, "Medicare Claims Processing Manual", Chapter 8, Section 60.3, 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 Product Codes

These codes are:

P9010	P9011	P9012	P9016	P9017
P9019	P9020	P9021	P9022	P9023

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P9031	P9032	P9033	P9034	P9035
P9036	P9037	P9038	P9039	P9040
P9044	P9050	P9051	P9052	P9053
P9054	P9055	P9056	P9057	P9058
P9059	P9060			

Also, payment for the following codes are applied to the blood deductible as instructed in the "Medicare General Information, Eligibility and Entitlement Manual", Chapter 3, Sections 20.5 through 20.5.4:

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 Section 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 Codes

86850	86860	86870	86880	86885
86866	86890	86891	86900	86901
86903	86904	86905	86906	89920
86921	86922	86923	86927	86930
86931	86932	86945	86950	86960
86965	86970	86971	86972	86975
86976	86977	86978	86985	

Reproductive Medicine Procedure Codes

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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

The official instruction, CR7654, issued to your FI, carrier and A/B MAC regarding this change, may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2365CP.pdf> on the CMS website.

If you have any questions, please contact your 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.

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