

Medicare Claims Processing Manual

Chapter 16 - Laboratory Services

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10 - Background

(Rev. 1, 10-01-03)

B3-2070, B3-2070.1, B3-4110.3, B3-5114

Diagnostic X-ray, laboratory, and other diagnostic tests, including materials and the services of technicians, are covered under the Medicare program. Some clinical laboratory procedures or tests require Food and Drug Administration (FDA) approval before coverage is provided.

A diagnostic laboratory test is considered a laboratory service for billing purposes, regardless of whether it is performed in:

- A physician's office, by an independent laboratory;
- By a hospital laboratory for its outpatients or nonpatients;
- In a rural health clinic; or
- In an HMO or Health Care Prepayment Plan (HCPP) for a patient who is not a member.

When a hospital laboratory performs laboratory tests for nonhospital patients, the laboratory is functioning as an independent laboratory, and still bills the fiscal intermediary (FI). Also, when physicians and laboratories perform the same test, whether manually or with automated equipment, the services are deemed similar.

Laboratory services furnished by an independent laboratory are covered under SMI if the laboratory is an approved Independent Clinical Laboratory. However, as is the case of all diagnostic services, in order to be covered these services must be related to a patient's illness or injury (or symptom or complaint) and ordered by a physician. A small number of laboratory tests can be covered as a preventive screening service.

See the Medicare Benefit Policy Manual, Chapter 15, for detailed coverage requirements.

See the Medicare Program Integrity Manual, Chapter 10, for laboratory/supplier enrollment guidelines.

See the Medicare State Operations Manual for laboratory/supplier certification requirements.

10.1 - Definitions

(Rev. 1, 10-01-03)

B3-2070.1, B3-2070.1.B, RHC-406.4

“Independent Laboratory” - An independent laboratory is one that is independent both of an attending or consulting physician’s office and of a hospital that meets at least the requirements to qualify as an emergency hospital as defined in [§1861\(e\)](#) of the Social Security Act (the Act.) (See the Medicare Benefits Policy Manual, Chapter 15, for detailed discussion.)

“Physician Office Laboratory” – A physician office laboratory is a laboratory maintained by a physician or group of physicians for performing diagnostic tests in connection with the physician practice.

“Clinical Laboratory” - See the Medicare Benefits Policy Manual, Chapter 15.

“Qualified Hospital Laboratory” - A qualified hospital laboratory is one that provides some clinical laboratory tests 24 hours a day, 7 days a week, to serve a hospital’s emergency room that is also available to provide services 24 hours a day, 7 days a week. For the qualified hospital laboratory meet this requirement, the hospital must have physicians physically present or available within 30 minutes through a medical staff call roster to handle emergencies 24 hours a day, 7 days a week; and hospital laboratory technologists must be on duty or on call at all times to provide testing for the emergency room.

“Hospital Outpatient” - See the Medicare Benefit Policy Manual, Chapter 2.

10.2 - General Explanation of Payment

(Rev. 1, 10-01-03)

B3-5114, HO-437, A3-3628, B3-5114.1, AB-03-076

Outpatient laboratory services can be paid in different ways:

- Physician Fee Schedule;
- Reasonable costs (Critical Access Hospitals (CAH) only);

NOTE: When the CAH bills a 14X bill type as a reference laboratory, the CAH is paid under the laboratory fee schedule.

- Laboratory Fee Schedule;
- Outpatient Prospective Payment System, (OPPS) except for most hospitals in the state of Maryland that are subject to waiver; or

- Reasonable Charge

Annually, CMS distributes a list of codes and indicates the payment method. Carriers and FIs pay as directed by this list. Neither deductible nor coinsurance applies to HCPCS codes paid under the laboratory fee schedule; further, deductible and coinsurance do not apply to HCPCS laboratory codes paid via reasonable cost to CAHs. The majority of outpatient laboratory services are paid under the laboratory fee schedule or the OPSS.

Carriers and FIs are responsible for applying the correct fee schedule for payment of clinical laboratory tests. FIs must determine which hospitals meet the criteria for payment at the 62 percent fee schedule. Only sole community hospitals with qualified hospital laboratories are eligible for payment under the 62 percent fee schedule. Generally, payment for diagnostic laboratory tests that are not subject to the clinical laboratory fee schedule is made in accordance with the reasonable charge or physician fee schedule methodologies (or reasonable costs for CAHs).

For Clinical Diagnostic Laboratory services denied due to frequency edits contractors must use standard health care adjustment reason code 151 - "Payment adjusted because the payer deems the information submitted does not support this many services."

20 - Calculation of Payment Rates - Clinical Laboratory Test Fee Schedules

(Rev. 1, 10-01-03)

HO-437, A3-3628, PM AB-98-7, B3-5114.1

Under Part B, for services rendered on or after July 1, 1984, clinical laboratory tests performed in a physician's office, by an independent laboratory, or by a hospital laboratory for its outpatients are reimbursed on the basis of fee schedules. Current exceptions to this rule are CAH laboratory services as described in [§10](#), and services provided by hospitals in the State of Maryland.

Medicare pays the lesser of:

- Actual charges;
- The fee schedule amount for the State or a local geographic area; or
- A national limitation amount (NLA) for the HCPCS code as provided by [§1834\(h\)](#) of the Act.

Annually, CMS furnishes to carriers and FIs the proper amount to pay for each HCPCS code for each local geographic area. This includes a calculation of whether a national limitation amount or the local fee schedule amount is to be used.

This information is available to the public on the CMS Web site in public use files.

20.1 - Initial Development of Laboratory Fee Schedules

(Rev. 1, 10-01-03)

HO-437, A3-3628, B3-5114.1.C

Initially, each carrier established the fee schedules on a carrier-wide basis (not to exceed a statewide basis). If a carrier's area includes more than one State, the carrier established a separate fee schedule for each State. The carrier determined the fee schedule amount based on prevailing charges for laboratory billings by physicians and independent laboratories billing the carrier. Carriers set the fees at 60 percent of prevailing charges. FIs used the same fee schedules to pay outpatient hospital laboratory services. They set the fee at 62 percent of carrier prevailing charges. Subsequently, except for sole community hospitals, which continue to be paid at the 62 percent rate, FIs changed payments to hospital laboratories to the "60 percent fee schedule."

In 1994, CMS took over the annual update and distribution of clinical laboratory fee schedules. The CMS updates the fee schedule amounts annually to reflect changes in the Consumer Price Index (CPI) for all Urban Consumers (U.S. city average), or as otherwise specified by legislation.

Effective for hospital outpatient tests furnished by a hospital on or after April 1, 1988, to receive the 62 percent fee the hospital must be a sole community hospital. Otherwise, the fee is the "60 percent fee schedule." If a hospital is uncertain whether it meets the qualifications of a sole community hospital it can seek assistance from the FI or the RO.

For tests to hospital nonpatients, the fee is 60 percent of the carrier prevailing charge. If a hospital laboratory acts as an independent laboratory, i.e., performs tests for persons who are nonhospital patients; or if the hospital laboratory is not a qualified hospital laboratory, the services are reimbursed using the 60 percent fee schedule or the adjusted fee schedule, as appropriate.

See [§10.1](#) for the definition of a hospital outpatient.

20.2 - Annual Fee Schedule Updates

(Rev. 1, 10-01-03)

The CMS adjusts the fee schedule amounts annually to reflect changes in the Consumer Price Index (CPI) for all Urban Consumers (U.S. city average), or as otherwise specified by legislation. The CMS also determines, publishes for contractor use, and places on its web site, coding and pricing changes. A CMS issued temporary instruction informs contractors when and where the updates are published.

30 - Special Payment Considerations

(Rev. 1, 10-01-03)

30.1 - Mandatory Assignment for Laboratory Tests

(Rev. 1, 10-01-03)

B3-5114.1

Unless a laboratory, physician, or medical group accepts assignment, the carrier makes no Part B payment for laboratory tests paid on the laboratory fee schedule. Laboratories, physicians, or medical groups that have entered into a participation agreement must accept assignment. Sanctions of double the violation charges, civil money penalties (up to \$2,000 per violation), and/or exclusion from the program for a period of up to five years may be imposed on physicians and laboratories, with the exception of rural health clinic laboratories, that knowingly, willfully, and repeatedly bill patients on an unassigned basis. However, sole community physicians and physicians who are the sole source of an essential specialty in a community are not excluded from the program. Whenever a carrier is notified of a sanction action for this reason, the carrier does not pay for any laboratory services unless the services were furnished within 15 days after the date on the exclusion or suspension notice to the practitioner, and:

- It is the first claim filed for services rendered to that beneficiary after the date on the notice of suspension or exclusion; or
- It is filed with respect to services furnished within 15 days of the date on the first notice of denial of claims to the beneficiary. (Fifteen days are allowed for the notice to reach the beneficiary.)

Carriers refer questions on payment procedures to the Sanctions Coordinator in the RO.

Carriers process laboratory claims inadvertently submitted as unassigned as if they were assigned. (See [§50](#).)

For purposes of this section, the term assignment includes assignment in the strict sense of the term as well as the procedure under which payment is made, after the death of the beneficiary, to the person or entity that furnished the service, on the basis of that person's or entity's agreement to accept the Medicare payment as the full charge or fee for the service.

30.1.1 - Rural Health Clinics

(Rev. 1, 10-01-03)

PM A-99-8, Rev. 810, CR 1133, PM A-00-30

Rural Health Clinics (RHCs) must furnish the following laboratory services to be approved as an RHC. However, these and other laboratory services that may be furnished are not included in the encounter rate and must be billed separately:

- Chemical examinations of urine by stick or tablet method or both;
- Hemoglobin or hematocrit;
- Blood sugar;
- Examination of stool specimens for occult blood;
- Pregnancy tests; and
- Primary culturing for transmittal to a certified laboratory (No CPT code available).

Effective January 1, 2001, freestanding RHCs/Federally Qualified Health Centers (FQHCs) bill all laboratory services to the carrier, and provider based RHCs/FQHCS bill all laboratory tests to the FI under the host provider's bill type. In either case payment is made under the fee schedule. HCPCS codes are required for laboratory services. (See [§40.4](#) for details on RHC billing.)

30.2 - Deductible and Coinsurance Application for Laboratory Tests

(Rev. 1, 10-01-03)

B3-2462, B3-5114.1, A3-3215, HHA-160

Neither the annual cash deductible nor the 20 percent coinsurance apply to:

- Clinical laboratory tests performed by a physician, laboratory, or other entity paid on an assigned basis;
- Specimen collection fees; or
- Travel allowance related to laboratory tests (e.g., collecting specimen).

Codes on the physician fee schedule are generally subject to the Part B deductible and coinsurance, although exceptions may be noted for a given code in the MPFS or through formal Medicare instructions such as temporary instructions and requirements for specific services noted in this manual.

Any laboratory code paid at reasonable charge is subject to the Part B deductible and coinsurance, unless otherwise specified in the description of coverage and payment rules.

Neither deductible nor coinsurance is applied to payment for codes on the laboratory fee schedule that are made to CAHs.

30.3 - Method of Payment for Clinical Laboratory Tests - Place of Service Variation

(Rev. 1, 10-01-03)

HO-437, A3-3628, B3-5114.1, PM A-01-31

The following apply in determining the amount of Part B payment for clinical laboratory tests, including those furnished under method II for ESRD beneficiaries:

Independent laboratory or a physician or medical group - Payment to an independent laboratory or a physician or medical group is the lesser of the actual charge, the fee schedule amount or the national limitation amount. Part B deductible and coinsurance do not apply.

Reference laboratory - For tests performed by a reference laboratory, the payment is the lesser of the actual charge by the billing laboratory, the fee schedule amount, or the national limitation amount. (See [§50.5](#) for carrier jurisdiction details.) Part B deductible and coinsurance do not apply.

Outpatient or a nonpatient of the hospital - Payment to a hospital for tests furnished for an outpatient or a nonpatient of the hospital is the lesser of the actual charge, the 60 percent fee schedule amount, or the 60 percent NLA. Part B deductible and coinsurance do not apply.

Inpatient without Part A - Payment to a hospital for tests performed for an inpatient without Part A coverage is made on a reasonable cost basis and is subject to Part B deductible and coinsurance. Payment to a SNF inpatient without Part A coverage is made under the laboratory fee schedule.

Inpatient or SNF patient with Part A - Payment to a hospital for laboratory tests furnished to an inpatient whose stay is covered under Part A, is included in the PPS rate for PPS facilities or is made on a reasonable cost basis for non-PPS hospitals. Payment for lab services for beneficiaries in a Part A stay in a SNF, other than a swing bed in a CAH are included in the SNF PPS rate. For such services provided in a swing bed CAH, payment is made on a reasonable cost basis.

Sole community hospital - Payment to a sole community hospital for tests furnished for an outpatient of that hospital, is the least of the actual charge, the 62 percent fee schedule amount, or the 62 percent NLA. The Part B deductible and coinsurance do not apply.

Waived Hospitals - Payment to a hospital which has been granted a waiver of Medicare payment principles for outpatient services is subject to Part B deductible and coinsurance unless otherwise waived as part of an approved waiver. Specifically, laboratory fee schedules do not apply to laboratory tests furnished by hospitals in States or areas that have been granted demonstration waivers of Medicare reimbursement principles for outpatient services. The State of Maryland has been granted such demonstration waivers. This also may apply to hospitals in States granted approval for alternative payment methods for paying for hospital outpatient services under [§1886\(c\)](#) of the Act.

Critical Access Hospital - For a CAH being reimbursed under the “Standard Method” of reimbursement (See Chapter 4), payment for clinical laboratory services furnished as an outpatient service is made on a reasonable cost basis. Critical Access Hospitals choosing the “Standard Method” are paid under the fee schedule for services when they function as a reference laboratory (bill type 14X).

CAHs choosing the “Optional Method” of reimbursement (see Chapter 4) are reimbursed at reasonable cost for non-professional clinical laboratory services and at 115 percent of the fee schedule for professional clinical laboratory services.

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

Dialysis facility - Payment to a hospital-based or independent dialysis facility for laboratory tests included under the ESRD composite rate payment and performed for a patient of that facility, is included in the facility’s composite rate payment for these tests and is subject to the Part B deductible and coinsurance. Laboratory tests that are not included under the ESRD composite rate payment; and are performed by an independent laboratory or a provider-based laboratory for dialysis patients of independent dialysis facilities or provider based facilities; are paid in addition to the composite rate payment and are subject to the fee schedule limits. This also applies to all laboratory tests furnished to home dialysis patients who have selected Payment Method II. These limits are 60 percent for all tests unless performed by a qualified hospital laboratory in a sole community hospital; in which case the 62 percent rate applies. The laboratory performing the tests must bill.

Rural health clinic - Payment to a rural health clinic (RHC) for laboratory tests performed for a patient of that clinic is not included in the all-inclusive rate and may be billed separately by the laboratory (including a laboratory that is part of a hospital that hosts a hospital based RHC). Payment for the laboratory service is not subject to Part B deductible and coinsurance. (See [§40.4](#) for details on RHC billing.)

Enrolled in Managed Care - Payment to a participating health maintenance organization (HMO) or health care prepayment plan (HCPP) for laboratory tests provided to a Medicare beneficiary who is an enrolled member is included in the monthly capitation amount.

Nonenrolled Managed Care - Payment to a participating HMO or HCPP for laboratory tests performed for a patient who is not a member is the lesser of the actual charge, or the fee schedule, or the NLA. The Part B deductible and coinsurance do not apply.

Hospice - Payment to a hospice for laboratory tests performed by the hospice is included in the hospice rate.

30.4 - Payment for Review of Laboratory Test Results by Physician

(Rev. 1, 10-01-03)

B3-5114.2

Reviewing results of laboratory tests, phoning results to patients, filing such results, etc., are Medicare covered services. Payment is included in the physician fee schedule payment for the evaluation and management (E and M) services to the patient. Visit services entail a wide range of components and activities that may vary somewhat from patient to patient. The CPT lists different levels of E and M services for both new and established patients and describes services that are included as E and M services. Such activities include obtaining, reviewing, and analyzing appropriate diagnostic tests.

40 - Billing for Clinical Laboratory Tests

(Rev. 1, 10-01-03)

40.1 - Laboratories Billing for Referred Tests

(Rev. 1, 10-01-03)

B3-5114.1.E,

Section [1833\(h\) \(5\)](#) of the Act provides that a referring laboratory may bill for tests for Medicare beneficiaries performed on or after May 1, 1990, by a reference laboratory only if the referring laboratory meets certain exceptions. In the case of a test performed at the request of a laboratory by another laboratory, payment may be made to the referring laboratory but only if one of the following three exceptions is met:

- The referring laboratory is located in, or is part of, a rural hospital;
- One of the following relationships exists between the referring laboratory and the entity performing the tests:
 - The referring laboratory is wholly owned by the entity performing such test;
 - the referring laboratory wholly owns the entity performing such test; or
 - both the referring laboratory and the entity performing such test are wholly-owned by a third entity (collectively, a related referring laboratory); or

- Not more than 30 percent of the clinical laboratory tests for which a nonrelated referring laboratory receives requests for testing during the year in which the test are performed by another laboratory.

In the case of a clinical laboratory test provided under an arrangement (as defined in [§1861\(w\)\(1\)](#)) made by a hospital, CAH or SNF, payment is made to the hospital or SNF.

Examples of 30 Percent Exception:

1. A laboratory receives requests for 200 tests, performs 139 tests, and refers 61 tests to a nonrelated laboratory.

All tests referred to a non-related laboratory are counted. Thus, 30.5 percent (61/200) of the tests are considered tests referred to a non-related laboratory and, since this exceeds the 30 percent standard, the referring laboratory may not bill for any Medicare beneficiary laboratory tests referred to a non-related laboratory.

2. A laboratory receives requests for 200 tests, performs 139 tests and refers 15 to a related laboratory and 46 to a nonrelated laboratory. Only 23 percent of the tests were referred to nonrelated laboratories. Since this is less than 30 percent, the referring laboratory may bill for all tests.

NOTE: This provision of §6111(b) of OBRA of 1989 has no effect on hospitals that are paid under [§1833\(h\)\(5\)\(A\)\(iii\)](#).

NOTE: Laboratory services provided to a SNF inpatient under Part A are billed by the SNF, not the laboratory, due to consolidated billing for SNFs.

40.2 - Payment Limit for Purchased Services

(Rev. 1, 10-01-03)

If a physician or laboratory bills the carrier for a laboratory test performed by an outside supplier, the fee schedule amount for the purchased service equals the lower of the billing physician's/laboratory's fee schedule or the price paid for the services.

For purchased services, the physician billing the carrier must identify the supplier (including the supplier's provider number) and the amount the supplier charged net of any discounts on the claim.

40.3 - Hospital Billing Under Part B

(Rev. 1, 10-01-03)

HO-437, A3-3628

Hospital laboratories, billing for either outpatient or nonpatient claims, bill the FI. Neither deductible nor coinsurance applies to laboratory tests paid under the fee schedule.

Hospitals must follow requirements for submission of the Form CMS-1450 (see Chapter 25 for billing requirements).

When the hospital obtains laboratory tests for outpatients under arrangements with clinical laboratories or other hospital laboratories, only the hospital can bill for the arranged services.

If all tests are for a nonpatient, the hospital may submit one bill and be reimbursed at 60 percent.

If the hospital is a sole community hospital identified in the PPS Provider Specific File with a qualified hospital laboratory identified on the hospital's certification; tests for outpatients are reimbursable at 62 percent. If tests are for an outpatient, those referred to a reference laboratory are considered nonpatient tests reimbursable at 60 percent.

If the hospital bills for both types of outpatient tests, it should prepare two bills: one for its own laboratory tests reimbursable at 62 percent, the other for the tests referred to the reference laboratory reimbursable at 60 percent. The CMS-1450 (UB-92) Type of Bill (TOB) code (FL4) for the nonpatient bill is 14X. The hospital includes fee schedule laboratory tests on the same bill with other outpatient services to the same beneficiary on the same day, unless it is billing for a reference laboratory as described above, in which case it submits a separate bill for the reference laboratory tests. Hospitals should not submit separate bills for laboratory tests performed in different departments on the same day.

40.3.1 - Critical Access Hospital (CAH) Outpatient Laboratory Service

(Rev. 1, 10-01-03)

HO-437, A3-3628, PM A-01-31

Effective for services furnished on or after the enactment of Balanced Budget Refinement Act of 1999 (BBRA), Medicare beneficiaries are not liable for any coinsurance, deductible, co-payment, or other cost sharing amount with respect to clinical laboratory services furnished as a CAH outpatient service. This change is effective for claims with dates of service on or after November 29, 1999, that were received July 1, 2001 or later.

For CAH bill type 85X, the laboratory fees are paid at cost with no cost-sharing.

When the CAH electing the standard reimbursement method (see chapter 3) bills a 14X bill type as a reference laboratory, it is paid the laboratory fee schedule rather than reasonable cost.

For CAHs billing as a reference laboratory (Bill Type 14X) and choosing the "Optional Method" of reimbursement (See Chapter 4) reimbursement is at reasonable cost for non-professional clinical laboratory services and at 115 percent of the fee schedule for professional clinical laboratory services.

40.4 - Special Skilled Nursing Facility (SNF) Billing Exceptions for Laboratory Tests

(Rev. 1, 10-01-03)

SNF 541, A3-3137.1, HO-437, B3-5114.1

When a SNF furnishes laboratory services directly, it must have a Clinical Laboratory Improvement Act (CLIA) number or a CLIA certificate of waiver, and the laboratory itself must be in the portion of the facility so certified. Normally the FI makes payment under Part B for clinical laboratory tests only to the entity that performed the test. However, the law permits SNFs to submit a Part B claim to the FI for laboratory tests that it makes arrangements for another entity to perform on the SNF's behalf. Section [1833\(h\)\(5\)](#) of the Act (as enacted by The Deficit Reduction Act of 1984, P.L. 98-369) requires the establishment of a fee schedule for clinical laboratory tests paid under Part B and also requires that, with certain exceptions, only the entity that performed the test may be paid.

The fee schedule applies to all SNF clinical laboratory services.

Where a SNF operates a laboratory that provides laboratory services to patients other than its own patients, it is functioning as a clinical laboratory. The billing for these laboratory services depends upon the HCPCS code as defined in the CMS annual fee schedule releases (laboratory and MPFS), and the arrangements made for payment with the referring entity (e.g., does the SNF or the referring entity bill under the agreement between the two). The SNF is responsible for ascertaining the necessary information for billing the FI. Any questions must be referred to the FI.

40.4.1 - Which Contractor to Bill for Laboratory Services Furnished to a Medicare Beneficiary in a Skilled Nursing Facility (SNF)

(Rev. 1, 10-01-03)

Inpatient Part A beneficiary - SNF bills the FI under Part A. The service is included in SNF PPS payment.

Inpatient Part B beneficiary (benefits exhausted or no Part A entitlement) - SNFs may provide the service and bill the FI, may obtain the service under arrangement and bill the FI under Part B, or may have agreement with a reference laboratory for the reference laboratory to provide the service and have the reference laboratory bill the carrier under Part B. Regardless of who bills, CMS policy requires that the service be paid under the fee schedule, whether or not the beneficiary is in a Medicare certified bed.

Outpatient Part B - See inpatient Part B beneficiary (benefits exhausted or no Part A entitlement), immediately above.

40.5 - Rural Health Clinic (RHC) Billing

(Rev. 1, 10-01-03)

B3-3628

For independent RHCs, laboratory services provided in the RHC's laboratory are not included in the all-inclusive rate payment to the RHC and may be billed separately to the carrier. This includes the six basic laboratory tests required for certification as well as any other laboratory tests provided in the RHC laboratory.

Note: If the RHC sends laboratory services to an outside laboratory, the outside laboratory bills the Part B carrier for the tests.

If the RHC laboratory becomes certified as a clinical laboratory, it bills all laboratory tests performed in its laboratory to the laboratory's Part B carrier. Laboratory tests are not included as RHC costs nor as part of the RHC all-inclusive rate payment.

For provider based RHCs the rules in the preceding paragraph apply with the following exception. The provider bills tests provided in its laboratory to the FI.

40.6 - Billing for End Stage Renal Disease (ESRD) Related Laboratory Tests

(Rev. 1, 10-01-03)

PM AB-98-7, PRM 1 2711, B3-4270.2

Hemodialysis, Intermittent Peritoneal Dialysis (IPD), and Continuous Cycling Peritoneal Dialysis (CCPD) Tests

With some exceptions, laboratory tests for hemodialysis, intermittent peritoneal dialysis (IPD), and continuous cycling peritoneal dialysis (CCPD) are included in the ESRD composite rate.

For a particular date of service to a beneficiary, if 50 percent or more of the covered laboratory tests are noncomposite rate tests Medicare allows separate payment beyond that included in the composite rate

For a description of what laboratory tests and other tests are included in the composite rate and under what conditions such tests may qualify for additional payment in addition to the composite rate, see the Medicare Benefit Policy Manual Chapter 11, "End Stage Renal Disease (ESRD)," and Chapter 8 of this manual.

Clinical diagnostic laboratory tests included under the composite rate payment are paid through the composite rate paid by the FI.

40.6.1 – Automated Multi-Channel Chemistry (AMCC) Tests for ESRD Beneficiaries - FIs

(Rev. 1, 10-01-03)

A-03-033

Medicare will apply the following rules to Automated Multi-Channel Chemistry (AMCC) tests for ESRD beneficiaries:

- Payment is at the lowest rate for services performed by the same provider, for the same beneficiary, for the same date of service.
- The facility must identify, for a particular date of service, the AMCC tests ordered that are included in the composite rate and those that are not included. See Chapter 8 for the composite rate tests for Hemodialysis, Intermittent Peritoneal Dialysis (IPD), Continuous Cycling Peritoneal Dialysis (CCPD), Hemofiltration, and Continuous Ambulatory Peritoneal Dialysis (CAPD).
- If 50 percent or more of the covered tests are included under the composite rate payment, then all submitted tests are included within the composite payment. In this case, no separate payment in addition to the composite rate is made for any of the separately billable tests.
- If less than 50 percent of the covered tests are composite rate tests, all AMCC tests submitted for that Date of Service (DOS) for that beneficiary are separately payable.
- A noncomposite rate test is defined as any test separately payable outside of the composite rate or beyond the normal frequency covered under the composite rate that is reasonable and necessary.

(See [§100.6](#) for details regarding pricing modifiers.)

The FI shared system must calculate the number of AMCC tests provided for any given date of service. The FI sums all AMCC tests with a CD modifier and divides the sum of all tests with a CD, CE, and CF modifier for the same beneficiary and provider for any given date of service

If the result of the calculation for a date of service is 50 percent or greater, the FI does not pay for the tests.

If the result of the calculation for a date of service is less than 50 percent, the FI pays for all of the tests.

All tests for a date of service must be billed on the monthly ESRD bill. Providers must send in an adjustment if they identify additional tests that have not been billed.

The organ and disease oriented panels (80049, 80051, 80054, and 80058) are subject to the 50 percent rule. Laboratory tests that are not covered under the composite rate and that are furnished to CAPD end stage renal disease (ESRD) patients dialyzing at home are billed in the same way as any other test furnished home patients.

Business Requirements for ESRD Reimbursement of AMCC Tests:

Requirement Number	Requirements	Responsibility
1.1	The FI shared system must RTP a claim for AMCC tests when a claim for that date of service has already been submitted.	Shared system
1.2	Based upon the presence of the CD, CE and CF payment modifiers, identify the AMCC tests ordered that are included and not included in the composite rate payment	Shared system
1.3	Based upon the determination of requirement 1.2, if 50 percent or more of the covered tests are included under the composite rate, no separate payment is made.	Shared system
1.4	Based upon the determination of requirement 1.2, if less than 50 percent are covered tests included under the composite rate, all AMCC tests for that date of service are payable.	Shared system
1.5	Reject line items that contain a procedure (identified in exhibit 1 and 2) with a modifier CE and a modifier 91 and no line item on the claim with modifier CE and no modifier 91.	Shared system
1.6	Reject line items that contain a procedure (identified in exhibits 1 and 2) with a modifier CF and a modifier 91 and no line item on the claim with modifier CF and no modifier 91.	Shared system
1.7	FI must return any claims for additional tests for any date of service within the billing period when the provider has already submitted a claim. Instruct the provider to adjust the first claim.	FI or Shared system
1.8	Do not apply the 50/50 rule to line items for one of the chemistries in exhibits 1 or 2 that contain modifiers CE or CF and modifier 91 on the line item.	Shared system

Examples of the Application of the 50/50 Rule

The following examples are to illustrate how claims should be paid. The percentages in the action section represent the number of composite rate tests over the total tests. If this percentage is 50 percent or greater, no payment should be made for the claim.

Example 1:

Provider Name: Jones Hospital

DOS 2/1/02

Claim/Services 82040 Mod 1
82310 Mod 1
82374 Mod 1
82435 Mod 1
82947 Mod 3
84295 Mod 3
82040 Mod 1 (Returned as duplicate)
84075 Mod 2
82310 Mod 2
84155 Mod 2

ACTION: 9 services total, 2 non-composite rate tests, 3 composite rate tests beyond the frequency, 4 composite rate tests; $4/9 = 44.4\% < 50\%$ pay at ATP 09

Example 2:

Provider Name: Bon Secours Renal Facility

DOS 2/15/02

Claim/Services 82040 Mod 2 and Mod 91
84450 Mod 2
82310 Mod 2
82247 Mod 3

82465 No modifier present

82565 Mod 3

84550 Mod 3

82042 Mod 1

84075 Mod 2

82435 Mod 2

82550 Mod 3

82947 Mod 3

82977 Mod 3

ACTION: 11 services total, 6 non-composite rate tests, 4 composite rate tests beyond the frequency, 1 composite rate test; $1/11 = .09.4\% < 50\%$ pay at ATP 11

Example 3:

Provider Name: Sinai Hospital Renal Facility

Bene 1: DOS 4/02/02

Claim/Services 82565 Mod 1

83615 Mod 1

82247 Mod 3

82248 Mod 3

82040 Mod 1

82450 Mod 1

82565 Mod 2

84550 Mod 3

82248 Mod 3 (Duplicate

ACTION: 8 services total, 4 composite rate tests; $4/8 = 50\%$, therefore no payment is made

Example 4:

Provider Name: Dr. Andrew Ross

Bene 1: DOS 6/01/02

Claim/Services 84460 Mod 3

82247 Mod

82248 Mod 3

82040 Mod 1

84075 Mod 1

84450 Mod 1

ACTION: 6 services total, 3 non-composite rate tests and 3 composite rate tests; 3/6 = 50%, therefore no payment. An overpayment should be recovered for the ATP 03 payment amount.

40.6.2 - Claims Processing for Separately Billable Tests for ESRD Beneficiaries

(Rev. 1, 10-01-03)

Clinical laboratory tests can be performed individually or in predetermined groups on automated profile equipment. If a test profile is performed see [§40.6.1](#). If a clinical laboratory test is performed individually, see [§40.6.2.1](#) or [§40.6.2.2](#) depending upon whether the patient is treated in a hospital-based or independent dialysis facility

40.6.2.1 - Separately Billable ESRD Laboratory Tests Furnished by Hospital-Based Facilities

(Rev. 1, 10-01-03)

Hospital-based facilities are reimbursed for the separately billable ESRD laboratory tests furnished to their outpatients following the same rules that apply to all other Medicare covered outpatient laboratory services furnished by a hospital.

40.6.2.2 - Separately Billable ESRD Laboratory Tests Furnished to Patients of Independent Dialysis Facilities - FIs

(Rev. 1, 10-01-03)

In accord with Medicare program rules, the FI pays the laboratory that provided the service for all separately billable ESRD clinical laboratory services furnished to patients of independent dialysis. Independent dialysis facilities with appropriate clinical

laboratory certification may bill their FI for any separately billable clinical laboratory tests they perform. The FI pays both laboratories and independent dialysis facilities for separately billable clinical laboratory tests according to the Medicare clinical laboratory fee schedule.

40.7 - Billing for Noncovered Clinical Laboratory Tests

(Rev. 1, 10-01-03)

B3-5114.1

Ordinarily, neither a physician nor a laboratory bills the Medicare Program for noncovered tests. However, if the beneficiary (or his/her representative) contends that a clinical laboratory test which a physician or laboratory believes is noncovered may be covered, the physician or laboratory must file a claim that includes the test to effectuate the beneficiary's right to a Medicare determination. The physician or laboratory annotates the claim that he/she believes that the test is noncovered and is submitting it at the beneficiary's insistence. Before furnishing a beneficiary a test which the physician or laboratory believes is excluded from coverage as not reasonable and necessary (rather than excluded from coverage as part of a routine physical check-up), the physician or laboratory must obtain a signed Advanced Beneficiary Notice (ABN) from the beneficiary (or representative) that the physician or laboratory has informed him/her of the noncoverage of the test and that there will be a charge for the test. This protects the physician or laboratory against possible liability for the test under the limitation of liability provision.

See Chapter 30, regarding Advance Beneficiary Notices (ABN) and demand bills..

50 – Carrier Claims Processing

(Rev. 1, 10-01-03)

50.1 - Referring Laboratories

(Rev. 1, 10-01-03)

B3-5114.1

Effective with services rendered on or after January 1, 1991, carriers deny bills from a referring laboratory for tests performed by a reference laboratory unless the carrier is informed in writing by the referring laboratory that the referring laboratory meets one of the exception criteria in [§40.1](#).

If it is later found that a referring laboratory does not, in fact, meet an exception criterion, the carrier should recoup payment for the referred tests improperly billed. If, after carrier notification, the referring laboratory persists in not identifying the laboratory to which the test(s) were referred, the carrier advises the RO. The RO takes whatever action is necessary to correct the problem.

50.2 - Physicians

(Rev. 1, 10-01-03)

B3-4110.2

If a physician or medical group furnishes laboratory tests in an office setting and it is appropriate for them to be performed in the physician's office, no further development of the source of the laboratory tests is required.

If a claim or physician's bill raises a question as to the source of a laboratory test and it cannot be resolved from available information, carriers must request the source of the laboratory service from the physician.

If the clinical laboratory test is subject to the laboratory fee schedule, carriers must pay only the person or entity that performed or supervised the performance of the test. However, carriers may also pay one physician for tests performed or supervised by another physician with whom he/she shares a practice, i.e., the two physicians are members of a medical group whose physicians submit claims in their own names rather than in the name of the group. Where the medical group submits claims in the name of the group for the services of the physician who performed or supervised the performance of these tests, carriers must pay the group. Regardless of who submits the claim, assignment is required for payment. See [§50.2.1](#) below.

50.2.1 - Assignment Required

(Rev. 1, 10-01-03)

B3-4110.2

Carriers must:

- Pay for clinical laboratory services provided in the physician's office only on an assignment basis.
- Treat as assigned any claims for clinical laboratory services provided in the physician's office even if the claimant submits the claim on a non-assigned basis or if the assignment option is not designated.
- Deny claims where it is apparent from the claims form or from other evidence that the beneficiary or provider refuses to assign. Use MSN notice 16.41 or 16.6 and remittance Remark code PR106 or CO111, as appropriate.

50.3 - Hospitals

(Rev. 1, 10-01-03)

50.3.1 - Hospital-Leased Laboratories

(Rev. 1, 10-01-03)

B3-4110.1

Carriers process claims from hospital laboratories that are leased by physicians and independent laboratories.

Before processing claims for services furnished by a hospital laboratory department operated on a lease or concession basis by a pathologist or by a nonphysician specialist such as a biochemist (with a visiting pathologist or outside independent laboratory doing the hospital's tissue work), carriers must ascertain if the laboratory has been approved by the RO.

Services furnished by a laboratory that does not meet the hospital laboratory conditions of participation and is operated under a lease arrangement in a domestic emergency hospital are covered only if they are emergency inpatient services payable under Part A.

Additional information concerning nonparticipating emergency hospital services is found in Chapter 3.

50.3.2 - Hospital Laboratory Services Furnished to Nonhospital Patients

(Rev. 1, 10-01-03)

B3-4110.5, HO-460

When a hospital laboratory performs a laboratory service for a nonhospital patient, (i.e., for neither an inpatient nor an outpatient), the hospital bills its FI on the Form CMS-1450. If a carrier receives such claims, the carrier should deny them. When a hospital-leased laboratory performs a service for a nonhospital patient, it must bill the carrier.

50.4 - Reporting of Pricing Localities for Clinical Laboratory Services

(Rev. 1, 10-01-03)

PM-B-97-12

For dates of services on or after January 1, 1998, CWF edits require that clinical laboratory services and drugs be reported with the appropriate carrier wide, statewide pricing locality. This edit ensures that valid pricing localities are submitted to CWF, and also promotes consistency in the reporting of pricing localities for clinical laboratory services and drugs.

Carriers must report pricing localities for clinical laboratory services and drugs to CWF using the following guidelines:

- Carriers assigned a single carrier wide, statewide pricing locality (i.e., a 00 or another single locality number) should submit that locality to CWF for clinical laboratory services and drugs.
- Carriers not assigned a single carrier wide, statewide pricing locality (i.e., more than one locality number) should use locality 00 for clinical laboratory services and drugs.

50.5 - Jurisdiction of Laboratory Claims

(Rev. 1, 10-01-03)

B3-3102

Jurisdiction of payment requests for laboratory services furnished by an independent laboratory, except where indicated in [§50.5.1](#) and [§50.5.2](#), lies with the carrier serving the area in which the laboratory test is performed. Jurisdiction is not affected by whether or not the independent laboratory uses a central billing office and whether or not the laboratory provides services to customers outside its carrier's service area.

50.5.1 - Referral Laboratory Services

(Rev. 1, 10-01-03)

B3-3102, B3-5114

The referring independent laboratory may obtain Medicare reimbursement for medically necessary covered tests if no more than 30 percent of the total annual clinical laboratory tests requested for the referring laboratory are performed by another laboratory.

If the specimen is drawn or received by an independent laboratory approved under the Medicare program and the laboratory performs a covered test but refers the specimen to another laboratory in a different carrier jurisdiction for additional tests, the carrier servicing the referring laboratory retains jurisdiction for services performed by the other laboratory only if it has, in house, the appropriate certification information as well as appropriate fee schedule allowance(s) of the performing laboratory. If the carrier with jurisdiction of the referring laboratory does not have this information, in house, the claims for services performed by other laboratories must be transferred to the carrier servicing the laboratory that performed the service. This rule applies whether or not the referring and reference laboratories are owned and controlled by the same entity or the reference laboratory deals only with other laboratories and not with patients and third party payers. In such cases, the referring independent laboratory must identify the performing laboratory on its bills.

NOTE: In no case should jurisdiction be determined by the location of a nonapproved pickup station.

If the approved independent laboratory that draws or receives the specimen does not perform covered services, but refers the specimen to another independent laboratory in a different carrier jurisdiction, the rules cited above apply.

50.5.2 - Examples of Independent Laboratory Jurisdiction

(Rev. 1, 10-01-03)

B3-3102

EXAMPLE 1

An independent laboratory located in Oregon performs laboratory services for physicians whose offices are located in several neighboring States. A physician from Nevada sends specimens to the Oregon laboratory.

If the laboratory sends the results to the physician and accepts assignment, the carrier in Oregon has jurisdiction.

EXAMPLE 2

American Laboratories, Inc., is an independent laboratory company with branch laboratories located in Philadelphia, PA and Wilmington, DE, as well as regional laboratories located in Millville, NJ and Boston, MA.

The Philadelphia laboratory receives a blood sample from a patient whose physician ordered a complete blood count, a metabolic panel and a B12 and folate. The Philadelphia laboratory performs the complete blood count, but the metabolic panel is performed at the Millville laboratory, while the B12 and folate is performed at the Boston Laboratory. The Pennsylvania carrier retains jurisdiction for processing the claims if they have certification information and the appropriate fee schedule allowance in house. Otherwise, the local carrier servicing Boston and/or Millville has jurisdiction for processing their claims.

EXAMPLE 3

Same relationships as in Example 2. American Laboratories, Inc., is an independent laboratory company with branch laboratories located in Philadelphia, PA and Wilmington, DE, as well as regional laboratories located in Millville, NJ and Boston, MA.

This time the Wilmington laboratory draws a blood specimen from a patient whose physician has ordered a blood culture. The Wilmington laboratory then sends the specimen to the Boston laboratory, which performs the required test. American Laboratories accepts an assignment for the service. If the carrier processing claims for

providers/suppliers located in Delaware has the capability of comparing the Wilmington laboratory's charge for the blood culture against the appropriate reasonable charge screens for the Boston laboratory, the carrier processing claims for Delaware will retain jurisdiction for processing the claim. If the carrier processing claims for providers/suppliers located in Delaware does not have this capability, the claim should be transferred to the Massachusetts carrier for processing.

60 - Specimen Collection Fee and Travel Allowance

(Rev. 1, 10-01-03)

B3-5114.1

60.1 - Specimen Collection Fee

(Rev. 1, 10-01-03)

B3-5114.1, A3-3628

In addition to the amounts provided under the fee schedules, the Secretary shall provide for and establish a nominal fee to cover the appropriate costs of collecting the sample on which a clinical laboratory test was performed and for which payment is made with respect to samples collected in the same encounter.

A specimen collection fee is allowed in circumstances such as drawing a blood sample through venipuncture (i.e., inserting into a vein a needle with syringe or vacutainer to draw the specimen) or collecting a urine sample by catheterization. A specimen collection fee is not allowed for blood samples where the cost of collecting the specimen is minimal (such as a throat culture or a routine capillary puncture for clotting or bleeding time). This fee will not be paid to anyone who has not extracted the specimen. Only one collection fee is allowed for each type of specimen for each patient encounter, regardless of the number of specimens drawn. When a series of specimens is required to complete a single test (e.g., glucose tolerance test), the series is treated as a single encounter.

60.1.1 - Physician Specimen Drawing

(Rev. 1, 10-01-03)

HO-437, A3-3628, B3-5114.1

Medicare allows a specimen collection fee for physicians only when (1) it is the accepted and prevailing practice among physicians in the locality to make separate charges for drawing or collecting a specimen, and (2) it is the customary practice of the physician performing such services to bill separate charges for drawing or collecting the specimen.

60.1.2 - Independent Laboratory Specimen Drawing

(Rev. 1, 10-01-03)

B3-4110.4, HO-437, A3-3628

Medicare allows separate charges made by laboratories for drawing or collecting specimens whether or not the specimens are referred to hospitals or independent laboratories. The laboratory does not bill for routine handling charges where a specimen is referred by one laboratory to another.

Medicare allows a specimen collection fee when it is medically necessary for a laboratory technician to draw a specimen from either a nursing home patient or homebound patient. The technician must personally draw the specimen, e.g., venipuncture or urine sample by catheterization. Medicare does not allow a specimen collection fee to the visiting technician if a patient in a facility is (a) not confined to the facility, or (b) the facility has personnel on duty qualified to perform the specimen collection. Medical necessity for such services exists, for example, where a laboratory technician draws a blood specimen from a homebound or an institutionalized patient. A patient need not be bedridden to be homebound. However, where the specimen is a type that would require only the services of a messenger and would not require the skills of a laboratory technician, e.g., urine or sputum, a specimen pickup service would not be considered medically necessary. (See Chapters 7 and 15 of the Medicare Benefit Policy Manual for a discussion of “homebound” and a more complete definition of a medically necessary laboratory service to a homebound or an institutional patient.)

In addition to the usual information required on claim forms (including the name of the prescribing physician), all independent laboratory claims for such specimen drawing or EKG services prescribed by a physician should be appropriately annotated, e.g., “patient confined to home,” “patient homebound,” or “patient in nursing home, no qualified person on duty to draw specimen.” Carriers must assure the validity of the annotation through scientific claims samples as well as through regular bill review techniques. (This could be done by use of the information in carrier files, and where necessary, contact with the prescribing physician.)

If a physician requests an independent laboratory to obtain specimens in situations which do not meet, or without regard to whether they meet, the medical necessity criteria in Chapter 15 of the Medicare Benefit Policy Manual, an educational contact with the prescribing physician is warranted and, where necessary, corroborating documentation should be obtained on claims until the carrier is assured that the physician prescribes such services only when the criteria are met.

60.1.3 - Specimen Drawing for Dialysis Patients

(Rev. 1, 10-01-03)

A3 3644.1, PR 2711.1, B3-4270.2, PUB-29 322

See the Medicare Benefit Policy Manual, Chapter 11, for a description of laboratory services included in the composite rate.

Independent laboratories and independent dialysis facilities with the appropriate clinical laboratory certification in accordance with CLIA may be paid for ESRD clinical laboratory tests that are separately billable. The laboratories and independent dialysis facilities are paid for separately billable clinical laboratory tests according to the Medicare laboratory fee schedule for independent laboratories. Independent dialysis facilities billing for separately billable laboratory tests that they perform must submit claims to the FI. Independent laboratories must bill the carrier.

Hospital-based laboratories providing laboratory service to hospital dialysis patients of the hospital's dialysis facility are paid in accordance with the outpatient laboratory provisions. However, where the hospital laboratory does tests for an independent dialysis facility or for another hospital's facility, the nonpatient billing provisions apply (see [§20.1](#)).

Clinical laboratory tests can be performed individually or in predetermined groups on automated profile equipment. A specimen collection fee determined by CMS (as of this writing, up to \$3.00) will be allowed only in the following circumstances:

- Drawing a blood sample through venipuncture (i.e., inserting into a vein a needle with a syringe or vacutainer to draw the specimen).
- Collecting a urine sample by catheterization.

Special rules apply when such services are furnished to dialysis patients. The specimen collection fee is not separately payable for y patients dialyzed in the facility or for patients dialyzed at home under reimbursement Method I. Payment for this service is included under the ESRD composite rate, regardless of whether the laboratory test itself is included in the composite rate or is separately billable.

Fees for taking specimens from home dialysis patients, who have elected reimbursement Method II may be paid separately, provided all other criteria for payment are met. Also, fees for taking specimens in the hospital setting, but outside of the dialysis unit, for use in performing laboratory tests not included in the ESRD composite rate may be paid separately.

60.1.4 - Coding Requirements for Specimen Collection

(Rev. 1, 10-01-03)

The following HCPCS codes and terminology must be used:

- G0001 - Routine venipuncture for collection of specimen(s).
- P9615 - Catheterization for collection of specimen(s).

The allowed amount for specimen collection in each of the above circumstances is included in the laboratory fee schedule distributed annually by CMS.

60.2 - Travel Allowance

(Rev. 1, 10-01-03)

HO-437, A3-3628.F, B3-5114.1K; PM-AB-99-49

In addition to a specimen collection fee allowed under [§60.1](#), Medicare, under Part B, covers a specimen collection fee and travel allowance for a laboratory technician to draw a specimen from either a nursing home patient or homebound patient under [§1833\(h\)\(3\)](#) of the Act and payment is made based on the clinical laboratory fee schedule. The travel allowance is intended to cover the estimated travel costs of collecting a specimen and to reflect the technician's salary and travel costs.

The additional allowance can be made only where a specimen collection fee is also payable, i.e., no travel allowance is made where the technician merely performs a messenger service to pick up a specimen drawn by a physician or nursing home personnel. The travel allowance may not be paid to a physician unless the trip to the home, or to the nursing home was solely for the purpose of drawing a specimen. Otherwise travel costs are considered to be associated with the other purposes of the trip.

The travel allowance is not distributed by CMS. Instead, the carrier must calculate the travel allowance for each claim using the following rules for the particular Code. The following HCPCS codes are used for travel allowances:

Per Mile Travel Allowance (P9603)

- The minimum "per mile travel allowance" is 75 cents. The per mile travel allowance is to be used in situations where the average trip to patients' homes is longer than 20 miles round trip, and is to be pro-rated in situations where specimens are drawn or picked up from non-Medicare patients in the same trip. - one way, in connection with medically necessary laboratory specimen collection drawn from homebound or nursing home bound patient; prorated miles actually traveled (carrier allowance on per mile basis); or
- The per mile allowance was computed using the Federal mileage rate plus an additional 44 cents a mile to cover the technician's time and travel costs. Contractors have the option of establishing a higher per mile rate in excess of the minimum (75 cents a mile in cy 2000) if local conditions warrant it. The minimum mileage rate will be reviewed and updated in conjunction with the clinical lab fee schedule as needed. At no time will the laboratory be allowed to bill for more miles than are reasonable or for miles not actually traveled by the laboratory technician.

Example 1: In CY 2000, a laboratory technician travels 60 miles round trip from a lab in a city to a remote rural location, and back to the lab to draw a single

Medicare patient's blood. The total reimbursement would be \$45.00 (60 miles x .75 cents a mile), plus the specimen collection fee of \$3.00.

Example 2: In CY 2000, a laboratory technician travels 40 miles from the lab to a Medicare patient's home to draw blood, and then travels an additional 10 miles to a non-Medicare patient's home and then travels 30 miles to return to the lab. The total miles traveled would be 80 miles. The claim submitted would be for one half of the miles traveled or \$30.00 (40 x .75), plus the specimen collection fee of \$3.00.

Flat Rate (P9604)

The CMS will pay a minimum of \$7.50 one way flat rate travel allowance. The flat rate travel allowance is to be used in areas where average trips are less than 20 miles round trip. The flat rate travel fee is to be pro-rated for more than one blood drawn at the same address, and for stops at the homes of Medicare and non-Medicare patients. The laboratory does the pro-ration when the claim is submitted based on the number of patients seen on that trip. The specimen collection fee will be paid for each patient encounter.

This rate is based on an assumption that a trip is an average of 15 minutes and up to 10 miles one way. It uses the Federal mileage rate and a laboratory technician's time of \$17.66 an hour, including overhead. Contractors have the option of establishing a flat rate in excess of the minimum of \$7.50, if local conditions warrant it. The minimum national flat rate will be reviewed and updated in conjunction with the clinical laboratory fee schedule, as necessitated by adjustments in the Federal travel allowance and salaries.

The claimant identifies round trip travel by use of the LR modifier

Example 3: A laboratory technician travels from the laboratory to a single Medicare patient's home and returns to the laboratory without making any other stops. The flat rate would be calculated as follows: 2 x \$7.50 for a total trip reimbursement of \$15.00, plus the specimen collection fee.

Example 4: A laboratory technician travels from the laboratory to the homes of five patients to draw blood, four of the patients are Medicare patients and one is not. An additional flat rate would be charged to cover the 5 stops and the return trip to the lab (6 x \$7.50 = \$45.00). Each of the claims submitted would be for \$9.00 (\$45.00 / 5 = \$9.00). Since one of the patients is non-Medicare, four claims would be submitted for \$9.00 each, plus the specimen collection fee for each.

Example 5: A laboratory technician travels from a laboratory to a nursing home and draws blood from 5 patients and returns to the laboratory. Four of the patients are on Medicare and one is not. The \$7.50 flat rate is multiplied by two to cover the return trip to the laboratory (2 x \$7.50 = \$15.00) and then divided by five (1/5 of \$15.00 = \$3.00).

Since one of the patients is non-Medicare, four claims would be submitted for \$3.00 each, plus the specimen collection fee.

If a carrier determines that it results in equitable payment, the carrier may extend the former payment allowances for additional travel (such as to a distant rural nursing home) to all circumstances where travel is required. This might be appropriate, for example, if the carrier's former payment allowance was on a per mile basis. Otherwise, it should establish an appropriate allowance and inform the suppliers in its service area. If a carrier decides to establish a new allowance, one method is to consider developing a travel allowance consisting of:

- The current Federal mileage allowance for operating personal automobiles, plus a personnel allowance per mile to cover personnel costs based upon an estimate of average hourly wages and average driving speed.

Carriers must prorate travel allowance amounts claimed by suppliers by the number of patients (including Medicare and non-Medicare patients) from whom specimens were drawn on a given trip.

The carrier may determine that payment in addition to the routine travel allowance determined under this section is appropriate if:

- the patient from whom the specimen must be collected is in a nursing home or is homebound; and
- the clinical laboratory tests are needed on an emergency basis outside the general business hours of the laboratory making the collection.

70 - Clinical Laboratory Improvement Amendments (CLIA) Requirements

(Rev. 1, 10-01-03)

A3-3628.2, RHC-640, ESRD 322, HO-306, HHA-465, SNF 541, HO-437.2, PM B-97-3

70.1 - Background

(Rev. 1, 10-01-03)

A3-3628.2, PM B-97-4

The Clinical Laboratory Improvements Amendments of 1988 (CLIA), Public Law 100-578, amended §353 of the Public Health Service Act (PHSA) to extend jurisdiction of the Department of Health and Human Services to regulate all laboratories that examine human specimens to provide information to assess, diagnose, prevent, or treat any disease or impairment. The purpose of the CLIA program is to assure that laboratories testing specimens in interstate commerce consistently provide accurate procedures and services.

As a result of CLIA, any laboratory soliciting or accepting specimens in interstate commerce for laboratory testing is required to hold a valid license or letter of exemption from licensure issued by the Secretary of HHS. The term “interstate commerce” means trade, traffic, commerce, transportation, or communication between any state, possession of the United States, the Commonwealth of Puerto Rico, or the District of Columbia, and any place outside thereof, or within the District of Columbia.

CLIA mandates that virtually all laboratories, including physician office laboratories (POLs), meet applicable Federal requirements and have a CLIA certificate in order to receive reimbursement from Federal programs. CLIA also lists requirements for laboratories performing only certain tests to be eligible for a certificate of waiver or a certificate for Physician Performed Microscopy Procedures (PPMP). Since 1992, carriers have been instructed to deny clinical laboratory services billed by independent laboratories which did not meet the CLIA requirements. POLs were excluded from the 1992 instruction but included in 1997.

The CLIA number must be included on each Form CMS-1500 claim for laboratory services by any laboratory performing tests covered by CLIA.

70.2 - Billing

(Rev. 1, 10-01-03)

The CLIA number is required in field 23 of the paper Form CMS-1500. The electronic formats have a field reserved for a CLIA number. See Chapter 26 for specific reporting requirements.

70.3 - Verifying CLIA Certification

(Rev. 1, 10-01-03)

A3-3628.2

CWF edits Carrier claims to ascertain that the laboratory identified by the CLIA number is certified to perform the test. (CWF uses data supplied from the certification process.) See Chapter 27 for related specifications.

Providers that bill FIs are responsible for verifying CLIA certification prior to ordering laboratory services under arrangement. The survey process validates that these providers have procedures in place to insure that laboratory services are provided by CLIA approved laboratories. See the Medicare State Agency Manual for details.

70.4 - CLIA Numbers

(Rev. 1, 10-01-03)

A3-3628.2.D

The structure of the CLIA number follows:

Positions 1 and 2 contain the State code (based on the laboratory's physical location at time of registration);

Position 3 contains the letter "D"; and

Positions 4-10 contain the unique CLIA system assigned number that identifies the laboratory. (No other laboratory in the country has this number.)

Initially, providers are issued a CLIA number when they apply to the CLIA program.

Independent dialysis facilities must obtain a CLIA certificate in order to perform clotting time tests.

70.5 - CLIA Categories and Subcategories

(Rev. 1, 10-01-03)

A laboratory may be licensed or exempted from licensure in several major categories of procedures. These major categories are:

010	Histocompatibility
100	Microbiology
110	Bacteriology
115	Mycobacteriology
120	Mycology
130	Parasitology
140	Virology
150	Other Microbiology
200	Diagnostic Immunology
210	Syphilis Serology
220	General Immunology
300	Chemistry
310	Routine
320	Urinalysis

330	Endocrinology
340	Toxicology
350	Other
400	Hematology
500	Immuno-hematology
510	ABO Group and RH Type
520	Antibody Detection (Transfusion)
530	Antibody Detection (Non Transfusion)
540	Antibody Identification
550	Compatability Testing
560	Other
600	Pathology
610	Histopathology
620	Oral Pathology
630	Cytology
800	Radioassay
900	Clinical Cytogenics

For a list of specific HCPCS codes see <http://www.cms.hhs.gov/clia/default.asp>

70.6 - Certificate for Physician-Performed Microscopy Procedures

(Rev. 12, 10-24-03) See Business Requirements at http://www.cms.hhs.gov/manuals/pm_trans/R12CP.pdf

A3-3628.2.E

Effective January 19, 1993, a laboratory that holds a certificate for physician-performed microscopy procedures may perform only those tests specified as physician-performed microscopy procedures and waived tests, as described below, and no others.

HCPCS Code	Test
Q0111	Wet mounts, including preparations of vaginal, cervical or skin specimens
Q0112	All potassium hydroxide (KOH) preparations
Q0113	Pinworm examinations
Q0114	Fern test
Q0115	Post-coital direct, qualitative examinations of vaginal or cervical mucous
81015	Urine sediment examinations

70.7 - Deleted - Held for Expansion

(Rev. 1, 10-01-03)

70.8 - Certificate of Waiver

(Rev. 1, 10-01-03)

A3-3628.2, PM AB-01-95

Effective September 1, 1992, all laboratory testing sites (except as provided in [42 CFR 493.3\(b\)](#)) must have either a CLIA certificate of waiver or certificate of registration to legally perform clinical laboratory testing anywhere in the United States.

The CMS identifies CLIA waived tests. The list of waived tests may change periodically. Some CLIA tests are implicitly waived based on procedure codes and some must have a QW modifier to be recognized as a waived test. Carriers are given the waived code revisions via a CMS issued temporary instruction on a quarterly basis.

For a list of specific HCPCS codes subject to CLIA see <http://www.cms.hhs.gov/clia/default.asp>

70.9 - CLIA License or Licensure Exemption

(Rev. 1, 10-01-03)

See the Medicare State Operations Manual.

70.10 - CLIA Number Submitted on Form CMS-1500

(Rev. 1, 10-01-03)

Effective with services provided October 1, 1997, any independent laboratory performing tests covered by CLIA must submit the CLIA number on the Form CMS-1500 hardcopy or electronic claim form. The CLIA number is reported in:

- Field 23 of the paper CMS-1500,
- Record FAO, field 34 of the NSF,
- ASC X12 837 (3051) REF segment as REF02, with qualifier of “X4” in REF01
- ASC X12 837 (4010) REF segment as REF02, with qualifier of “X4” in REF01

The CLIA number is not required on UB 92 or its related data sets.

See Chapter 26 for detailed format instructions.

Laboratory claims submitted without the CLIA number are returned as unprocessable. If the CLIA number is submitted on the claim, but is inconsistent with the CLIA format, the carrier returns the claim as unprocessable. If more than one CLIA number is submitted on the claim, except when a reference laboratory is on the same claim, the carrier returns the claim as unprocessable.

If the tests on one claim have been performed in more than one Physician Office Laboratory (POL) by the same physician, the appropriate CLIA number should be associated with the test that was performed in each laboratory. In such a case, the physician must submit a separate claim for each location (CLIA number) where a test was performed.

70.10.1 - Physician Notification of Denials

(Rev. 1, 10-01-03)

If there is no CLIA number on the claim, the carrier sends RA messages MA 120 and MA 130, which state:

MA 120 - Did not complete or enter accurately the CLIA number.

MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit the correct information to the appropriate FI or carrier.

70.11 - Reasons for Denial - Physician Office Laboratories Out-of-Compliance

(Rev. 1, 10-01-03)

Carriers use remittance advice (RA) message B7 to notify the provider of the reason for denial. The B7 message states: "This provider was not certified/eligible to be paid for this procedure/service on this date of service."

Carriers use MSN message #14.1, which states:

The laboratory is not approved for this type of test.

80 - Issues Related to Specific Tests

(Rev. 1, 10-01-03)

80.1 - Screening Services

(Rev. 1, 10-01-03)

See Chapter 18 for payment, edit and MSN requirements for the following screening services.

- Screening Pap Smear and Pelvic Examination
- Screening Prostate Tests
- Colorectal Cancer Screening

80.2 - Anatomic Pathology Services

(Rev. 1, 10-01-03)

A3-3628.1, SNF 541.1, HO-437.1, RHC-437, CIM 50.20.1, PM AB-98-7, AB-98-22, B-98-16, A-98-6, R103.CIM, A3-4603.1

Clinical laboratory tests include some services described as anatomic pathology services in CPT (i.e., certain cervical, vaginal, or peripheral blood smears). The CPT code 85060 is used only when a physician interprets an abnormal peripheral blood smear for a hospital inpatient or a hospital outpatient, and the hospital is responsible for the technical component. When an independent laboratory bills a physician interpretation of an abnormal peripheral blood smear, the service is considered a complete or global service, and is not billed under the CPT code 85060. A physician interpretation of an abnormal peripheral blood smear performed by an independent laboratory is considered a routine part of the ordered hematology service (i.e., those tests that include a different white blood count).

HCPCS code 88150 (cervical or vaginal smears) included both screening and interpretation in CPT 1986 terminology while the CPT 1987 terminology includes only screening. A new code, 88151, was added for those smears that require physician interpretation. Code 88151 is treated and priced in the same manner as code 88150 was previously treated and priced. Code 88151 with a “-26” modifier is paid when a physician performs an interpretation of an abnormal smear for a hospital inpatient or outpatient, and the hospital is responsible for the technical component. The “-26” modifier for code 88150 is no longer recognized. Code 88151(26) is priced as code 88150(26) would have been priced if the coding terminology had not been revised. Independent laboratories bill under code 88150 for normal smears and under code 88151 for abnormal smears. However, the fee schedule amount is equivalent.

80.2.1 - Technical Component (TC) of Physician Pathology Services to Hospital Patients

(Rev. 1, 10-01-03)

PM AB-02-177

Section 542 of the Benefits Improvement and Protection Act of 2000 (BIPA) provides that the Medicare carrier can continue to pay for the TC of physician pathology services when an independent laboratory furnishes this service to an inpatient or outpatient of a covered hospital. This provision applies to TC services furnished during the 2-year period beginning on January 1, 2001.

For this provision, covered hospital means a hospital that had an arrangement with an independent laboratory that was in effect as of July 22, 1999, under which a laboratory furnished the TC of physician pathology services to fee-for-service Medicare beneficiaries who were hospital inpatients or outpatients and submitted claims for

payment for the TC to a carrier. The TC could have been submitted separately or combined with the professional component and reported as a combined service.

The term “fee-for-service Medicare beneficiary” means an individual who:

1. Is entitled to benefits under Part A or enrolled under Part B of title XVIII or both; and
2. Is not enrolled in any of the following:
 - a. A Medicare + Choice plan under Part C of such title;
 - b. A plan offered by an eligible organization under [§1876](#) of the Act;
 - c. A program of all-inclusive care for the elderly under [§1894](#) of the Act; or
 - d. A social health maintenance organization demonstration project established under §4108(b) of the Omnibus Budget Reconciliation Act of 1987.

The following examples illustrate the application of the statutory provision to arrangements between hospitals and independent laboratories.

In implementing §542, the carriers should consider as independent laboratories those entities that it has previously recognized and paid as independent laboratories.

An independent laboratory that has acquired another independent laboratory that had an arrangement on July 22, 1999, with a covered hospital, can bill the TC of physician pathology services for that hospital’s inpatients and outpatients under the physician fee schedule.

EXAMPLE 1

Prior to July 22, 1999, independent laboratory A had an arrangement with a hospital in which this laboratory billed the carrier for the TC of physician pathology services. In July 2000, independent laboratory B acquires independent laboratory A. Independent laboratory B bills the carrier for the TC of physician pathology services for this hospital’s patients in 2001 and 2002.

If a hospital is a covered hospital, any independent laboratory that furnishes the TC of physician pathology services to that hospital’s inpatients or outpatients can bill the carrier for these services furnished in 2001 and 2002.

EXAMPLE 2:

As of July 22, 1999, the hospital had an arrangement with an independent laboratory, laboratory A, under which that laboratory billed the carrier for the TC of physician pathology service to hospital inpatients or outpatients. In 2001, the hospital enters into an arrangement with a different independent laboratory, laboratory B, under which

laboratory B wishes to bill its carrier for the TC of physician pathology services to hospital inpatients or outpatients. Because the hospital is a “covered hospital,” independent laboratory B can bill its carrier for the TC of physician pathology services to hospital inpatients or outpatients.

If the arrangement between the independent laboratory and the covered hospital limited the provision of TC physician pathology services to certain situations or at particular times, then the independent laboratory can bill the carrier only for these limited services.

An independent laboratory that furnishes the TC of physician pathology services to inpatients or outpatients of a hospital that is not a covered hospital may not bill the carrier for TC of physician pathology services furnished to patients of that hospital in 2001 or 2002.

An independent laboratory that has an arrangement with a covered hospital should forward a copy of this agreement or other documentation to its carrier to confirm that an arrangement was in effect between the hospital and the independent laboratory as of July 22, 1999. This documentation should be furnished for each covered hospital the independent laboratory services. If the laboratory did not have an arrangement with the covered hospital as of July 22, 1999, but has subsequently entered into an arrangement, then it should obtain a copy of the arrangement between the predecessor laboratory and the covered hospital and furnish this to the carrier. The carrier maintains a hard copy of this documentation for postpayment reviews.

The hospital cannot bill under the OPSS for the TC of physician pathology services if the independent laboratory that services that hospital outpatients is receiving payment from its carrier under the physician fee schedule.

80.3 - National Minimum Payment Amounts for Cervical or Vaginal Smear Clinical Laboratory Tests

(Rev. 1, 10-01-03)

PM AB-99-84, AB-99-99

For cervical or vaginal smear clinical laboratory tests, payment is the lesser of the local fee or the national limitation amount, but not less than the national minimum payment amount (NMPA). However, in no case may payment for these tests exceed actual charges. The Part B deductible and coinsurance do not apply.

For tests performed on or after January 1, 2000, a NMPA of \$14.60 is established and applies for cervical or vaginal smear clinical laboratory tests in accordance with §224 of the Balanced Budget Refinement Act (Public Law 106-113). The affected CPT laboratory test codes for the NMPA are 88142, 88143, 88144, 88145, 88147, 88148, 88150, 88152, 88153, 88154, 88164, 88165, 88166, 88167, G0123, G0143, G 0144, G0145, G0147, G0148, and P3000.

The NMPA will be reviewed and updated in conjunction with the clinical laboratory fee schedule, as required. Instructions for such updates will be sent to contractors through periodic temporary instructions.

80.4 - Oximetry

(Rev. 1, 10-01-03)

B3-5114.1

Certain blood gas levels are determined either by invasive means through use of a blood specimen for a clinical laboratory test or by noninvasive means through ear or pulse oximetry, which is not considered a clinical laboratory test. CPT code 82792 is used for invasive oximetry. HCPCS code M0592 is used for ear and pulse oximetry. Code M0592 is not subject to fee schedules.

90 - Automated Profile Tests and Organ/Disease Oriented Panels

(Rev. 1, 10-01-03)

The term “profile” or “panel” means a grouping of laboratory tests, which is usually performed automatically on a single piece of testing equipment.

90.1 - Laboratory Tests Utilizing Automated Equipment

(Rev. 1, 10-01-03)

B3-5114, HO-437, A3-3628

Clinical laboratory tests are covered under Medicare if they are reasonable and necessary for the diagnosis or treatment of an illness or injury. Because of the numerous technological advances and innovations in the clinical laboratory field and the increased availability of automated testing equipment, no distinction is generally made in determining payment for individual tests because of either (1) the sites where the service is performed, or (2) the method of the testing process used, whether manual or automated. Whether the test is actually performed manually or with automated equipment, the services are considered similar and the payment is the same.

However, where groups of tests that are billed individually may be done as a panel or profile, a determination must be made about whether payment should be made at the individual rate or at the panel or profile rate.

90.1.1 - Automated Test Listing

(Rev. 1, 10-01-03)

B3-5114, HO-437, A3-3628, PMs AB-97-5, AB-97-7, AB-97-17

Profiles are specific groupings of blood chemistries that enable physicians to more accurately diagnose their patients' medical problems. While the component tests in automated profiles may vary somewhat from one laboratory to another, or from one physician's office or clinic to another, in order to develop appropriate payment amounts, contractors group together those profile tests that can be performed at the same time on the same equipment. The carrier or FI must group together the individual tests in the profile when billed separately and consider the price of the related automated profile test. Payment cannot exceed the lower of the profile price or the totals of the prices of all the individual tests. (This rule is applicable also if the tests are done manually.) The profile HCPCS code and each individual test is priced at the lower of the billed charge or the fee amount; and payment is made at the lower of the profile/panel price or the total of the prices for all covered components.

Payment is made only for those tests in an automated profile that meet Medicare coverage rules. Where only some of the tests in a profile of tests are covered, payment cannot exceed the amount that would have been paid if only the covered tests had been ordered. For example, the use of the 12-channel serum chemistry test to determine the blood sugar level in a proven case of diabetes is unreasonable because the results of a blood sugar test performed separately provide the essential information. Normally, the payment allowance for a blood sugar test is lower than the payment allowance for the automated profile of tests. In no event, however, may payment for the covered tests exceed the payment allowance for the profile.

However, the carrier prices and pays the 1-22 automated multi-channel chemistry tests tested in [§90.2](#) at the lowest possible amount in accordance with [§90.3](#).

90.2 - Organ or Disease Oriented Panels

(Rev. 1, 10-01-03)

B3-5114, HO-437, A3-3628

Organ or disease panels must be paid at the lower of the billed charge, the fee amount for the panel, or the sum of the fee amounts for all components. When panels contain one or more automated tests, the carrier determines the correct price for the panel by comparing the price for the automated profile laboratory tests with the sum of the fee amounts for individual tests. Payment for the total panel may not exceed the sum total of the fee amounts for individual covered tests. All Medicare coverage rules apply.

The carrier shared system must calculate the correct payment amount. The CMS furnishes fee prices for each code but the carrier system must compare individual codes

billed with codes and prices for related individual tests. (With each HCPCS update, HCPCS codes are reviewed and the system is updated). Once the codes are identified, carriers publish panel codes to providers.

The only acceptable Medicare definition for the component tests included in the CPT codes for organ or disease oriented panels is the American Medical Association (AMA) definition of component tests. The CMS will not pay for the panel code unless all of the tests in the definition are performed. If the laboratory has a custom panel that includes other tests, in addition to those in the defined CPT or HCPCS panels, the additional tests, whether on the list of automated tests or not, are billed separately in addition to the CPT or HCPCS panel code.

NOTE: If a laboratory chooses, it can bill each of the component tests of these panels individually, but payment will be based upon the above rules.

TABLE OF CHEMISTRY PANELS

		Hepatic Function Panel 80076	Basic Metabolic 80048	Comprehensive Metabolic 80053	Renal Function Panel 80069	Lipid* Panel 80061	Electrolyte Panel 80051
Chemistry	CPT Code						
Albumin	82040	X		X	X		
Alkaline phosphatase	84075	X		X			
ALT (SGPT)	84460	X		X			
AST (SGOT)	84450	X		X			
Bilirubin, total	82247	X		X			
Bilirubin, direct	82248	X					
Calcium	82310		X	X	X		
Chloride	82435		X	X	X		X
Cholesterol	82465					X	
CK, CPK	82550						
CO2 (bicarbonate)	82374		X	X	X		X
Creatinine	82565		X	X	X		

		Hepatic Function Panel 80076	Basic Metabolic 80048	Comprehensive Metabolic 80053	Renal Function Panel 80069	Lipid* Panel 80061	Electrolyte Panel 80051
Chemistry	CPT Code						
GGT	82977						
Glucose	82947		X	X	X		
LDH	83615						
Phosphorus	84100				X		
Potassium	84132		X	X	X		X
Protein, total	84155	X		X			
Sodium	84295		X	X	X		X
Triglycerides	84478					X	
Urea nitrogen (BUN)	84520		X	X	X		
Uric Acid	84550						

90.3 - Claims Processing Requirements for Panel and Profile Tests

(Rev. 1, 10-01-03)

PM AB-97-17

All test codes should be processed and stored in history as they are submitted. That is, if tests are submitted as individual CPT codes together and paid as a panel (see [§90](#)), the claim history data will reflect the individual codes and the panel used in pricing. All tests must maintain their identity as billed.

Prior to January 1, 1998, automated panel codes were adjudicated only on a line-by-line basis with application of the correct coding initiative (CCI) edits for duplicate detection.

Beginning with processing date January 1, 1998, when individual automated test codes are received, carriers and FIs do not combine them into panels for processing. The only instance in which they should be panel codes is when they are coded as such on the claim.

Panels must be processed line by line, and must be compared to other claims with automated test panels and/or single laboratory HCPCS codes in the current processing cycle, plus previous paid/processed claims. Therefore, any and all automated tests must be paid as a panel, but still retain their individual identity for duplicate detection and medical necessity review.

Carriers and FIs

1. Deny Duplicates. Deny duplicate services detected within the same processing cycle or stored in an automated history file. Consider claims that match on the following items as duplicates

- a. The service was performed by the same provider,
- b. For the same beneficiary, and
- c. For the same date of service.

2. Medical Necessity. Determine medical necessity. This process permits the identification of CPT codes subject to local medical review policies.

3. Process Claims. The processes shown below (A-H) should be followed to price and pay claims for automated panels (as defined in HCPCS) and individual tests. This does not replace or abridge any current procedures in place concerning the adjudication of claim. This is a general procedure for combining these services to attain the lowest pricing outcome. This display is an example only. System maintainers have the flexibility to vary these procedures as long as they attain the same result.

- A. Unbundle all panels to single lines representing individual automated tests, and identify duplicate tests within the claim. On concurrently processed claims, determine the total amount payable based on the combination of all tests billed by the same laboratory for the same date of service.
- B. Check history for automated laboratory services provided on the same day, same beneficiary, and the same provider. Unbundle any panels. Identify duplicate services. Aggregate all nonduplicate services for pricing (include the submitted charge and paid amounts for both individually or paneled billed claims). If a single organ disease panel or a single chemistry panel contains the only automated test claims for that date of service, adjudicate as billed.
- C. Compare each line's submitted charge to the fee schedule for that code (including automated tests retrieved from history).
- D. Sum the comparisons of the line by line.
- E. Obtain the fee for all automated tests as a panel including all services in history. If organ disease (OD) panels are involved, this would include fees for no automated test included in the OD panel.

- F. Carry forward the lesser of items D or E.
- G. Subtract from item F any previous automated laboratory test (individual or paneled) or organ disease panel containing automated tests payments. If nothing is payable on the claim, allow it with no payment (a zero pay claim allowance. CWF must allow these claims into their process).
- H. The amount payable is the total payable based on the combination of current and previously processed claims, less the total amount paid on the previous claim(s).
- I. If a claim is a CLIA reject from the CWF, Recycle that claim through the payment process to recalculate payment.

90.3.1 - History Display

(Rev. 1, 10-01-03)

When displaying claims payment for each CPT code in history, contractors apply the following rules:

1. If all component tests of any panel are allowed because the individual line item comparison is less than the fee (item D above is less than item E), record the panel codes as determined on the line-by-line comparison.
2. If all component tests are paid based on the panel price, allocate the current payment proportionate to the amount submitted for each CPT code.
3. If any panel tests will be denied or there are previously paid automated laboratory tests (as indicated by a check of beneficiary history), allocate the current payment amount by allowed line proportionate to what was submitted for the current claim being processed.

For administration of pricing requirements and/or invalid coding policies, contractors must establish a processing sequence for concurrently processed claims based on ascending order of internal control number (ICN). In the case of pricing, they must process the “first claim” (i.e., lower CN) based solely on the billed codes on that claim, process the “second” claim based on a combination of the billed codes on both claims and pay the balance due after subtracting the amount paid on the “first” claim. In the case of unacceptable code combinations, contractors must deny the “second” claim.

90.3.2 - Medicare Secondary Payer

(Rev. 1, 10-01-03)

When processing claims involving Medicare secondary payer (MSP), carriers should use the MSP payment formula as follows:

When Medicare is secondary, Medicare pays the lowest of:

- The actual charge less the primary payment;
- The amount Medicare would pay if primary; or
- The higher of the Medicare or primary allowable less the primary payment.

The two-step pricing comparison described above is required for calculating MSP amounts.

90.4 - Evaluating the Medical Necessity for Laboratory Panel CPT Codes

(Rev. 1, 10-01-03)

PM-B-98-1

The American Medical Association's (AMA) 1998 edition of the Current Procedural Terminology (CPT) establishes three new and one revised Organ or Disease Oriented laboratory panels. Since these panels are composed of clinically relevant groupings of automated multi-channel tests there is a general presumption of medical necessity. If contractors suspect abuse of the new panel codes, they should review such claims. Should a contractor determine the need to develop a LMRP for laboratory panel codes, the contractor should develop such a policy at the panel code level. As appropriate, a contractor may review the panel and deny component tests on a case-by-case basis or evaluate the need for the component level test.

90.5 - Special Processing Considerations

(Rev. 1, 10-01-03)

PM AB-97-17

To order any of the 22 automated tests, a physician may select individual tests or the panel. A physician may order a mix of panels and individual tests. The physician should review what tests are in each panel and not order individual tests that might duplicate tests in the panel. Medicare denies duplicate tests.

Specialists are not, based on their specialty, restricted to ordering certain panels or individual tests. The physician (general practitioner or specialist) should identify which tests he/she requires; and, if the tests match a grouping, order the appropriate panel. The claimant should file a separate claim for tests not included in a panel.

Claimants should use the QP modifier with the single ordering of tests or when a single code is available for groupings of tests. This modifier indicates that the claimant has documentation on file showing that the laboratory test(s) was ordered individually or

ordered as a CPT-recognized panel other than automated profile codes 80002-80019, G0058, G0059, and G0060.

100 - CPT Codes Subject to and Not Subject to the Clinical Laboratory Fee Schedule

(Rev. 1, 10-01-03)

HO-437, A3-3628, B3-5114.1

For fee schedule purposes, clinical laboratory services include most laboratory tests listed in codes 80048-89399 of CPT-1996. The CMS issues an update to the laboratory fee schedule each year, with information about whether prices have been determined by CMS or whether the individual carrier must determine the allowable charge.

Codes not included are not paid under the laboratory fee schedule but may be paid under the MPFS if covered for Medicare.

100.1 - Deleted - Held for Expansion

(Rev. 1, 10-01-03)

100.2 - Laboratory Tests Never Subject to the Fee Schedule

(Rev. 1, 10-01-03)

Some CPT codes in the 80000 series are not clinical laboratory tests and are therefore never subject to fee schedule limitations. Some of these codes are exempted because they are not clinical laboratory services. They include codes for procedures, services, blood products and auto-transfusions. They include codes such as whole blood, various red blood cell products, platelets, plasma, and cryoprecipitate. Other codes for tests primarily associated with the provision of blood products are also not considered to be clinical tests. Such tests identify various characteristics of blood products, but are not diagnostic in nature. These include various blood cross matching techniques. If they are covered, Medicare pays exclusion codes under the MPFS, reasonable charges, reasonable costs, or OPFS as applicable.

100.3 - Procedures Not Subject to Fee Schedule When Billed With Blood Products

(Rev. 1, 10-01-03)

The following codes are not subject to fee schedule limitations when submitted for payment on the same bill with charges for blood products. Rather, assume they are to be used for blood matching and not for diagnostic purposes.

Codes: 86901, 86905, 86930-86932, 86920-86922, 86890, 86870, 86891, 86880-86886, 86971, and 86930.

If no blood product is provided and billed for on the same claim, assume the codes are diagnostic and subject to the clinical laboratory fee schedule.

The shared system provides for this processing.

100.4 - Not Otherwise Classified Clinical Laboratory Tests

(Rev. 1, 10-01-03)

The following codes for unlisted or not otherwise classified (NOC) clinical laboratory tests are not subject to the NLA:

81099 87999

84999 88299

85999 89399

86999

NOC codes shall suspend for review and the carrier shall determine a price for them.

100.5 - Other Coding Issues

(Rev. 1, 10-01-03)

100.5.1 - Tests Performed More Than Once on the Same Day

(Rev. 1, 10-01-03)

PM AB-98-7

When it is necessary to obtain multiple results in the course of treatment, the modifiers 59 or 91 are used to indicate that a test was performed more than once on the same day for the same patient. The 91 modifier is used for laboratory tests paid under the clinical laboratory fee schedule.

These modifiers may be used to indicate that a test was performed more than once on the same day for the same patient, only when it is necessary to obtain multiple results in the course of treatment. These modifiers may not be used when tests are rerun to confirm initial results; due to testing problems with specimens and equipment; or for any other reason when a normal, one-time, reportable result is all that is required. These modifiers may not be used when there are standard HCPCS codes available that describe the series of results (e.g., glucose tolerance tests, evocative/suppression testing, etc.). These

modifiers may be used only for laboratory tests paid under the clinical laboratory fee schedule.

Improper use of modifiers is likely to indicate a fraudulent or abusive circumstance. When informing laboratories of the availability of modifiers, carriers are to emphasize that these modifiers have very narrow application and that any evidence of excessive use will be referred to Carrier/FI Program Integrity Unit for further review.

100.6 - Pricing Modifiers

(Rev. 1, 10-01-03)

PM A-03-033

Three pricing modifiers discretely identify the different payment situations for ESRD Automated Multi-Channel Chemistry (AMCC) tests. The physician that orders the tests is responsible for identifying the appropriate modifier when ordering the tests. The modifiers are in the following listing:

- CD - AMCC test has been ordered by an ESRD facility or MCP physician that is part of the composite rate and is not separately billable
- CE - AMCC test has been ordered by an ESRD facility or MCP physician that is a composite rate test but is beyond the normal frequency covered under the rate and is separately reimbursable based on medical necessity
- CF - AMCC test has been ordered by an ESRD facility or MCP physician that is not part of the composite rate and is separately billable

ESRD clinical laboratory tests identified with modifiers “CD,” “CE,” or “CF” may not be billed as organ or disease panels. Effective October 1, 2003, all ESRD clinical laboratory tests must be billed individually.

110 - Coordination Between Carriers and Other Entities

(Rev. 1, 10-01-03)

B3-5114.1

110.1 - Coordination Between Carriers and FIs/RRB

(Rev. 1, 10-01-03)

The carrier furnishes copies of fees that are locally established under the fee schedules (price code = 22) to Medicare FIs and to the appropriate RRB carrier. The carrier must provide updates at least 30 days prior to the carrier’s scheduled implementation of the update. The FIs add these fees to system fee schedule tables to use in paying for hospital laboratory tests performed for both outpatients of the hospital and persons who are not

patients of the hospital. The RRB contractor uses the fee schedules in paying for outpatient clinical laboratory tests.

FIs and the RRB may consult with carriers on filling gaps in fee schedules for tests where the carrier may not have established an amount. If an FI or the RRB carrier has bills for payment on laboratory tests for which the carrier has not furnished amounts, it consults with the area carrier. If necessary the area carrier consults with other nearby carriers.

110.2 - Coordination With Medicaid

(Rev. 1, 10-01-03)

Carriers furnish copies of the fee schedules and the annual update (including NLAs where applicable) to State agencies (SAs). Carriers provide updates to SAs at least 30 days prior to the scheduled implementation. To obtain Federal matching funds for clinical laboratory services, State Medicaid agencies may not pay more than Medicare pays for the services and specimen collections..

Since the fee schedule provisions were implemented on a carrier wide basis, a State may have more than one carrier servicing Medicare beneficiaries residing in the State. A Medicaid agency for such a State may, if it deems necessary, use the fee schedules of either one or both of the carriers to meet the Federal fund-matching requirement. State Medicaid agencies may consult with ROs concerning the fee schedule, the NLAs, and specimen collection provisions.

110.3 - Coordination With FIs and Providers

(Rev. 1, 10-01-03)

HO-437, A3-3628

There may be procedures hospitals bill for outpatients that are not included in the fee schedule. Where gaps occur, hospitals should work out procedures with the FI so that the hospital can secure the missing information promptly. Price Codes established by the carrier to fill gaps are valid until replaced by the earlier of permanent codes or the next annual update.

110.4 - Carrier Contacts With Independent Clinical Laboratories

(Rev. 1, 10-01-03)

B3-2070.1.F

An important role of the carrier is as a communicant of necessary information to independent clinical laboratories. Failure to inform independent laboratories of Medicare regulations and claims processing procedures may have an adverse effect on prosecution of laboratories suspected of fraudulent activities with respect to tests performed by, or billed on behalf of, independent laboratories. United States Attorneys often must

prosecute under a handicap or may refuse to prosecute cases where there is no evidence that a laboratory has been specifically informed of Medicare regulations and claims processing procedures.

To assure that laboratories are aware of Medicare regulations and carrier's policy, notification must be sent to independent laboratories when any changes are made in coverage policy or claims processing procedures. Additionally, to completely document efforts to fully inform independent laboratories of Medicare policy and the laboratory's responsibilities, previously issued newsletters should be periodically re-issued to remind laboratories of existing requirements.

Some items which should be discussed are the requirements to have the same charges for Medicare and private patients, to document fully the medical necessity for collection of specimens from a skilled nursing facility or a beneficiary's home, and, in cases when a laboratory service is referred from one independent laboratory to another independent laboratory, to identify the laboratory actually performing the test.

Additionally, when carrier professional relations representatives make personal contacts with particular laboratories, they should prepare and retain reports of contact indicating dates, persons present, and issues discussed.

120 - Clinical Laboratory Services Based on the Negotiated Rulemaking

(Rev. 1, 10-01-03)

PM AB-02-129

Section 4554(b)(1) of the Balanced Budget Act (BBA), Public Law 105-33 mandated the use of a negotiated rulemaking committee to develop national coverage and administrative policies for clinical laboratory services payable under Part B of Medicare. The BBA required that these national policies be designed to promote program integrity and national uniformity; and to simplify administrative requirements with respect to clinical diagnostic laboratory services payable under Part B.

These changes apply to every diagnostic clinical laboratory service that is payable under Medicare Part B. Neither the place where the service was performed, nor the type of contractor that will process the request for payment, has any effect on the applicability of these policies. A clinical laboratory service done in a hospital laboratory, independent laboratory, physician/practitioner office laboratory or other type of CLIA approved laboratory service is subject to these administrative policies.

The final rule did not affect the requirement that all physician claims must have a diagnosis. If a physician submits a claim for a service performed in a physician office laboratory, that claim is considered a physician claim and must meet the requirements for physician claims.

120.1 - Negotiated Rulemaking Implementation

(Rev. 1, 10-01-03)

B-03-045 (regarding requirement for diagnosis code)

Date of Service

The following requirements apply to service providers:

- The date of service should be reported as the date of specimen collection.
- The person obtaining the specimen must furnish the date of collection for the specimen to the entity billing Medicare.
- For specimen collections that span more than a 24-hour period, the date of service should be reported as the date the collection began.
- For laboratory tests that require a specimen from stored collections, the date of service should be defined as the date the specimen was obtained from the archives.
- If a situation occurs that does not correspond to the two situations described, the contractor will submit the question to the RO with the appropriate documentation. The RO will contact the Division of Supplier Claims Processing in CMS, which will serve as the point of contact.

Matching of Diagnosis to Procedure

During claims processing and adjudication, the contractor adheres to the following:

- If there is a LMRP or NCD for one or more of the services included on the claim, the contractor reviews all of the diagnosis codes in making a determination regarding medical necessity of the service.
- Even though a claim matches diagnosis to procedure in accordance with an NCD, other rules of adjudication may apply, which could result in denial.
- Diagnoses are required on all claims.

Physicians Reporting Diagnosis Codes When A Diagnostic Test Is Ordered

Section 4317 of the Balanced Budget Act of 1997 provides, with respect to diagnostic laboratory and certain other services, that “if the Secretary (or fiscal agent of the Secretary) requires the entity furnishing the services to provide diagnostic or other medical information to the entity, the physician or practitioner ordering the service shall provide that information to the entity at the time the service is ordered by the physician or practitioner.” A laboratory or other provider must report on a claim for Medicare

payment the diagnostic code(s) furnished by the ordering physician. In the absence of such coding information, the laboratory or other provider may determine the appropriate diagnostic code based on the ordering physician's narrative diagnostic statement or seek diagnostic information from the ordering physician/practitioner. However, a laboratory or other provider may not report on a claim for Medicare payment a diagnosis code in the absence of physician-supplied diagnostic information supporting such code.

Clarification of the Use of the Term "Screening" or "Screen"

The final rule clarifies that effective February 21, 2002, the use of the term "screening" or "screen" in CPT code descriptor does not necessarily describe a test performed in the absence of signs and symptoms of illness, disease or condition. Contractors do not deny a service based solely on the presence of the term "screening" or "screen" in the descriptor.

Tests that are performed in the absence of signs, symptoms, complaints, personal history of disease, or injury are not covered except when there is a statutory provision that explicitly covers tests for screening as described.

If a person is tested to rule out or to confirm a suspected diagnosis because the patient has a sign and/or symptoms, this is considered a diagnostic test, not a screening test. Contractors have discretionary authority to make reasonable and necessary scope of benefit determinations.

Exhibit 1

			Monthly	Weekly	13 X quarter
Chemistry		CPT Code			
1	Albumin	82040	X		
2	Alkaline phosphatase	84075	X		
3	ALT (SGPT)	84460			
4	AST (SGOT)	84450	X		
5	Bilirubin, total	82247			
6	Bilirubin, direct	82248			
7	Calcium	82310	X		
8	Chloride	82435			
9	Cholesterol	82465			
10	CK, CPK	82550			
11	CO2 (bicarbonate)	82374	X		
12	Creatinine	82565	X		
13	GGT	82977			
14	Glucose	82947			
15	LDH	83615	X		
16	Phosphorus	84100	X		
17	Potassium	84132	X		
18	Protein, total	84155	X		
19	Sodium	84295	X		
20	Triglycerides	84478			
21	Urea Nitrogen (BUN)	84520	X		
22	Uric Acid	84550			
			= non-composite rate test		
			= composite rate test		

Exhibit 2

			Monthly	Weekly	13 X quarter
Chemistry		CPT Code			
1	Albumin	82040	X		
2	Alkaline phosphatase	84075	X		
3	ALT (SGPT)	84460			
4	AST (SGOT)	84450	X		
5	Bilirubin, total	82247			
6	Bilirubin, direct	82248			
7	Calcium	82310	X		
8	Chloride	82435			
9	Cholesterol	82465			
10	CK, CPK	82550			
11	CO2 (bicarbonate)	82374	X		
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