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CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2823	**Date: November 22, 2013**
	Change Request 8517

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

I. SUMMARY OF CHANGES: This Recurring Update Notification (RUN) provides instructions for the CY 2014 clinical laboratory fee schedule, mapping for new codes for clinical laboratory tests, and updates for laboratory costs subject to the reasonable charge payment. This Recurring Update Notification applies to chapter 16, section 20.

EFFECTIVE DATE: January 1, 2014
IMPLEMENTATION DATE: January 6, 2014

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor's activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Recurring Update Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 2823	Date: November 22, 2013	Change Request: 8517

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

EFFECTIVE DATE: January 1, 2014
IMPLEMENTATION DATE: January 6, 2014

I. GENERAL INFORMATION

A. Background: This Recurring Update Notification (RUN) provides instructions for the CY 2014 clinical laboratory fee schedule, mapping for new codes for clinical laboratory tests, and updates for laboratory costs subject to the reasonable charge payment.

B. Policy: Update to Fees

In accordance with Section 1833(h)(2)(A)(i) of the Social Security Act (the Act), as amended by Section 628 of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, and further amended by Section 3401 of the Patient Protection and Affordable Care Act (PPACA) of 2010, the annual update to the local clinical laboratory fees for CY 2014 is (-0.75) percent. The annual update to local clinical laboratory fees for CY 2014 reflects an additional multi-factor productivity adjustment and a (-1.75) percentage point reduction as described by the PPACA legislation. The annual update to payments made on a reasonable charge basis for all other laboratory services for CY 2014 is 1.80 percent (See 42 CFR 405.509(b)(1)). Section 1833(a)(1)(D) of the Act provides that payment for a clinical laboratory test is the lesser of the actual charge billed for the test, the local fee, or the national limitation amount (NLA). For a cervical or vaginal smear test (pap smear), Section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount (described below). However, for a cervical or vaginal smear test (pap smear), payment may also not exceed the actual charge. The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

National Minimum Payment Amounts

For a cervical or vaginal smear test (pap smear), Section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount. Also, payment may not exceed the actual charge. The CY 2014 national minimum payment amount is $14.42 ($14.53 plus (-0.75) percent update for CY 2014). The affected codes for the national minimum payment amount are 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88164, 88165, 88166, 88167, 88174, 88175, G0123, G0143, G0144, G0145, G0147, G0148, and P3000.

National Limitation Amounts (Maximum)

For tests for which NLAs were established before January 1, 2001, the NLA is 74 percent of the median of the local fees. For tests for which the NLAs are first established on or after January 1, 2001, the NLA is 100 percent of the median of the local fees in accordance with Section 1833(h)(4)(B)(viii) of the Act.

Access to Data File

The CY 2014 clinical laboratory fee schedule data file shall be retrieved electronically through CMS' mainframe telecommunications system. Carriers shall retrieve the data file on or after November 19, 2013. Intermediaries shall retrieve the data file on or after November 19, 2013. Internet access to the CY 2014

clinical laboratory fee schedule data file shall be available after November 19, 2013, at http://www.cms.hhs.gov/ClinicalLabFeeSched. Other interested parties, such as the Medicaid State agencies, the Indian Health Service, the United Mine Workers, and the Railroad Retirement Board, shall use the Internet to retrieve the CY 2014 clinical laboratory fee schedule. It will be available in multiple formats: Excel, text, and comma delimited.

Data File Format

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

Public Comments

On July 10, 2013, CMS hosted a public meeting to solicit input on the payment relationship between CY 2013 codes and new CY 2014 CPT codes. Notice of the meeting was published in the Federal Register on May 24, 2013, and on the CMS Web site approximately June 1, 2013. Recommendations were received from many attendees, including individuals representing laboratories, manufacturers, and medical societies. CMS posted a summary of the meeting and the tentative payment determinations on the Web site at http://www.cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html. Additional written comments from the public were accepted until October 30, 2013. CMS has posted a summary of the public comments and the rationale for the final payment determinations on the CMS Web site.

Pricing Information

The CY 2014 clinical laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615). The fees have been established in accordance with Section 1833(h)(4)(B) of the Act.

The fees for clinical laboratory travel codes P9603 and P9604 are updated on an annual basis. The clinical laboratory travel codes are billable only for traveling to perform a specimen collection for either a nursing home or homebound patient. If there is a revision to the standard mileage rate for CY 2014, CMS will issue a separate instruction on the clinical laboratory travel fees.

The CY 2014 clinical laboratory fee schedule also includes codes that have a "QW" modifier to both identify codes and determine payment for tests performed by a laboratory having only a certificate of waiver under the Clinical Laboratory Improvement Amendments (CLIA).

Organ or Disease Oriented Panel Codes

Similar to prior years, the CY 2014 pricing amounts for certain organ or disease panel codes and evocative/suppression test codes were derived by summing the lower of the clinical laboratory fee schedule amount or the NLA for each individual test code included in the panel code. The NLA field on the data file is zero-filled.

Mapping Information

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

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

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

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

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

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

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

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

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

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

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

Existing code 81161 is to be covered and gap filled.

New code 81287 is to be gap filled.

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

Laboratory Costs Subject to Reasonable Charge Payment in CY 2014

For outpatients, the following codes are paid under a reasonable charge basis (See Section 1842(b)(3) of the Act). In accordance with 42 CFR 405.502 through 42 CFR 405.508, the reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update. The inflation-indexed update is calculated using the change in the applicable Consumer Price Index for the 12-month period ending June 30 of each year as set forth in 42 CFR 405.509(b)(1). The inflation-indexed update for CY 2014 is 1.8 percent.

Manual instructions for determining the reasonable charge payment can be found in Pub. 100-4, Medicare Claims Processing Manual, Chapter 23, Section 80 through 80.8. If there is insufficient charge data for a code, the instructions permit considering charges for other similar services and price lists.

When services described by the Healthcare Common Procedure Coding System (HCPCS) in the following list are performed for independent dialysis facility patients, Pub. 100-04, Medicare Claims Processing Manual, Chapter 8, Section 60.3 instructs that the reasonable charge basis applies. However, when these services are performed for hospital-based renal dialysis facility patients, payment is made on a reasonable cost basis. Also, when these services are performed for hospital outpatients, payment is made under the hospital outpatient prospective payment system (OPPS).

Blood Products

P9010

P9011

P9012

P9016

P9017

P9019

P9020

P9021

P9022

P9023

P9031

P9032

P9033

P9034

P9035

P9036

P9037

P9038

P9039

P9040

P9044

P9050

P9051

P9052

P9053

P9054

P9055

P9056

P9057

P9058

P9059

P9060

Also, payment for the following codes should be applied to the blood deductible as instructed in Pub. 100-01, Medicare General Information, Eligibility and Entitlement Manual, Chapter 3, Section 20.5 through 20.5.4:

P9010

P9016

P9021

P9022

P9038

P9039

P9040

P9051

P9054

P9056

P9057

P9058

NOTE: Biologic products not paid on a cost or prospective payment basis are paid based on Section 1842(o) of the Act. The payment limits based on Section 1842(o), including the payment limits for codes P9041, P9043, P9045, P9046, P9047, and P9048, should be obtained from the Medicare Part B drug pricing files.

Transfusion Medicine

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Reproductive Medicine Procedures

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II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8517.1	Carriers shall retrieve the CY 2014 Clinical Laboratory Fee Schedule data file (filename: MU00.@BF12394.CLAB.CY14.V1119) from the CMS mainframe on or after November 19, 2013.		X										
8517.1.1	Carriers shall notify CMS of successful receipt via e-mail to price_file_receipt@cms.hhs.gov stating the name of the file received and the entity for which it was received (e.g., carrier name and number).		X										
8517.2	Intermediaries shall retrieve the CY 2014 Clinical Laboratory Fee Schedule data file (filename: MU00.@BF12394.CLAB.CY14.V1119.FI) from the CMS mainframe on or after November 19, 2013.	X											
8517.2.1	Intermediaries shall notify CMS of successful receipt via e-mail to price_file_receipt@cms.hhs.gov stating the name of the file received and the entity for which it was received (e.g., fiscal intermediary name and number).	X											
8517.3	Contractors shall not search their files to either retract payment or retroactively pay claims; however, contractors should adjust claims if they are brought to their attention.	X	X										
8517.4	Carriers shall determine the reasonable charge for the codes identified as paid under the reasonable charge basis.		X										
8517.5	Carriers shall determine customary and prevailing charges by using data from July 1, 2012, through June 30, 2013, updated by the inflation-index update for year CY 2014 of 1.80 percent.		X										
8517.6	Intermediaries shall determine payment on a reasonable cost basis when these services are performed for hospital-based renal dialysis facility patients.	X											

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8517.7	If there is a revision to the standard mileage rate for CY 2014, CMS shall issue a separate instruction on the clinical laboratory travel fees.												CMS

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
8517.8	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X						

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Glenn McGuirk, 410-786-5723 or Glenn.McGuirk@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
No additional funding will be provided by CMS; contractor's activities are to be carried out within their operating budgets.

Section B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.