MLN Matters
Information for Medicare Fee-for-Service Health Care Professionals

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2005 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

Note: This article was revised to contain web addresses that conform to the new CMS website and to show they are now MLN Matters articles. All other information remains the same.

Provider Types Affected

Clinical laboratories

Provider Action Needed

This article and related CR3526 contains important information regarding the 2005 annual updates to the clinical laboratory fee schedule and for laboratory costs related to services subject to reasonable charge payments. It is important that affected laboratories understand these changes to assure correct and accurate payments from Medicare.

Background

Update to Clinical Laboratory Fees

In accordance with §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, the annual update to the local clinical laboratory fees for 2005 is zero (0) percent.

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), §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), §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 2005 national minimum payment amount is $14.76 ($14.76 plus zero percent update for 2005). The affected codes for the national minimum payment amount include the following:

88142	88143	88147	88148	88150	88152	88153
88154	88164	88165	88166	88167	88174	88175
G0123	G0143	G0144	G0145	G0147	G0148	P3000

National Limitation Amounts (Maximum)

For tests for which NLAs were established before January 1, 2001, the NLA is 74 percent of the median of the local fees. For tests for which 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 §1833(h)(4)(B)(viii) of the Act.

Access to 2005 Clinical Laboratory Fee Schedule

Internet access to the 2005 clinical laboratory fee schedule data file should be available after November 18, 2004, at *http://www.cms.hhs.gov/ClinicalLabFeeSched/* on the CMS website.

Interested providers should use the Internet to retrieve the 2005 clinical laboratory fee schedule. It will be available in multiple formats: Excel, text, and comma delimited.

Public Comments

On July 26, 2004, the Centers for Medicare & Medicaid Services (CMS) hosted a public meeting to solicit input on the payment relationship between 2004 codes and new 2005 Current Procedural Terminology (CPT) codes. The meeting

announcement was published in the Federal Register on May 28, 2004, pages 30658-30659, and on the CMS web site.

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 its website at http://www.cms.hhs.gov/ClinicalLabFeeSched/. Additional written comments from the public were accepted until September 24, 2004.

Comments after the release of the 2005 laboratory fee schedule can be submitted to the following address, so that CMS may consider them for the development of the 2006 laboratory fee schedule.

Centers for Medicare & Medicaid Services (CMS)
Center for Medicare Management
Division of Ambulatory Services
Mailstop: C4-07-07
7500 Security Boulevard
Baltimore, Maryland 21244-1850

A comment should be in written format and include clinical, coding, and costing information. To make it possible for CMS and its contractors to meet a January 3, 2006 implementation date, comments must be submitted before August 1, 2005.

Additional Pricing Information

The 2005 laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615). For dates of service January 1, 2005 through December 31, 2005, the personnel payment is $.45 per mile. For dates of service January 1, 2005 through December 31, 2005, the standard mileage rate for transportation costs is $.385. The 2005 payment for code P9603 is $.835 and for code P9604 it is $8.35.

The 2005 laboratory fee schedule also includes codes that have a "QW" modifier to both identify codes and determine payment for tests performed by a laboratory registered with only a certificate of waiver under the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

CPT code 36415 for *Collection of venous blood by venipuncture* is now payable by Medicare, but code 36416 *Collection of capillary blood specimen (e.g., finger, heel, ear stick)* remains as not payable by Medicare as a separate service.

Organ or Disease Oriented Panel Codes

Similar to prior years, the 2005 pricing amounts for certain organ or disease panel codes and evocative/suppression test codes were determined by Medicare by

summing the lower of the fee schedule amount or the NLA for each individual test code included in the panel code.

Mapping Information for New and Revised Codes

New Code:	Is Priced at the same rate as:
82045	83880
82656	83516
83009	83013
83630	83516
84163	84702
84166	the sum of 84165 and 87015
84450QW	84450
86064	86359
86335	the sum of 86334 and 87015
86379	86359
86587	86359
87807	87804

Laboratory Costs Subject to Reasonable Charge Payment in 2005

For outpatients, the codes in the following tables are paid under a reasonable charge basis. In accordance with §42 CFR 405.502 – 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 for year 2005 is 3.3 percent.

Manual instructions for determining the reasonable charge payment can be found in the Medicare Claims Processing Manual, Pub. 100-04, chapter 23, §80-80.8. (The Web address for this manual is provided in the "Additional Information" section below.) If there is insufficient charge data for a code, the instructions permit considering charges for other similar services and price lists.

When these services are performed for independent dialysis facility patients, the *Medicare Claims Processing Manual,* Pub. 100-04, Chapter 8, §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, the following codes should be applied to the blood deductible as instructed Pub. 100-01, Chapter 3, §20.5-20.54:

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 §1842(o) of the Act. The payment limits based on section 1842(o), including the payment limits for codes P9041 P9043 P9045 P9046 P9047 P9048, should be obtained from the Medicare Part B Drug Pricing Files.

Transfusion Medicine

86850	86860	86870	86880	86885	86886	86890
86891	86900	86901	86903	86904	86905	86906
86920	86921	86922	86927	86930	86931	86932
86945	86950	86965	86970	86971	86972	86975
86976	86977	86978	86985	G0267		

Reproductive Medicine Procedures

89250	89251	89253	89254	89255	89257	89258
89259	89260	89261	89264	89268	89272	89280
89281	89290	89291	89335	89342	89343	89344
89346	89352	89353	89354	89356		

Implementation

The changes for 2005 will be implemented on January 3, 2005.

Additional Information

Instructions for calculating reasonable charges are located in the Medicare Claims Processing Manual (Pub. 100-04) chapter 23, sections 80-80.8. at *http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf* on the CMS website.

The official instruction issued to your carrier/intermediary regarding this change may be found by going to *http://www.cms.hhs.gov/transmittals/Downloads/R363CP.pdf* the CMS website.

For additional information relating to this issue, please contact your carrier or intermediary on their toll free phone number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.