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Implementation Date: January 3, 2006

2006 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

Provider Types Affected

Clinical laboratories

Provider Action Needed

This article and related CR4144 contain important information regarding:

- The 2006 annual updates to the clinical laboratory fee schedule;
- Mapping for new codes for clinical laboratory tests; and
- Laboratory costs related to services subject to reasonable charge payments.

It is important that affected laboratories understand these changes to ensure 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 2006 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).

The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

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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 2006 national minimum payment amount is \$14.76 (\$14.76 plus zero percent update for 2006). The affected codes for the national minimum payment amount include the following Current Procedure Terminology (CPT) codes:

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 2006 Clinical Laboratory Fee Schedule

Internet access to the 2006 clinical laboratory fee schedule data file should be available after November 18, 2005, at http://www.cms.hhs.gov/ClinicalLabFeeSched/02_clinlab.asp#TopOfPage on the CMS web site.

Interested providers should use the Internet to retrieve the 2006 clinical laboratory fee schedule. It will be available in multiple formats: Excel™, text, and comma-delimited.

Public Comments

On July 18, 2005, the Centers for Medicare & Medicaid Services (CMS) hosted a public meeting to solicit input regarding the payment relationship between 2005 codes and new 2006 CPT codes. The meeting announcement was published in the *Federal Register* on May 27, 2005, and on the CMS web site on June 20, 2005.

Recommendations were received from many attendees, including individuals representing laboratories, manufacturers, and medical societies. Additional written comments from the public were accepted until September 23, 2005.

Comments after the release of the 2006 laboratory fee schedule can be submitted to the address listed below so that CMS may consider them for the development of the 2007 laboratory fee schedule. Comments should be in written format and include clinical, coding, and costing information. To make it possible for CMS and

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its contractors to meet a January 3, 2007 implementation date, comments must be submitted before August 1, 2006 to:

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

Additional Pricing Information

The 2006 laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615).

For dates of service on or after September 1, 2005, the fee for clinical laboratory travel code P9603 is \$0.935 per mile and for code P9604 is \$9.35 per flat rate trip basis. The clinical laboratory travel codes are billable only for traveling to perform a specimen collection for either a nursing home or homebound patient.

The standard mileage rate for transportation costs was increased by the federal government's Treasury Department to 48.5 cents a mile effective September 1, 2005 and this increase is incorporated into the fees for travel codes P9603 and P9604. If the federal government revises the standard mileage rate for calendar year 2006 or a portion of 2006, CMS will issue a separate notice regarding the change.

The 2006 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).

Organ or Disease Oriented Panel Codes

Similar to prior years, the 2006 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

This information is shown in the following table:

New Code:	Is Priced At The Same Rate As:	New Code:	Is Priced At The Same Rate As:
80195	80197	82271	82270
82271QW	82270	82272	82270
82272QW	82270	83631	The sum of 83520 and 87015
83695	83520	83700	Deleted code 83715
83701	Deleted code 83716	83704	The sum of deleted codes

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New Code:	Is Priced At The Same Rate As:	New Code:	Is Priced At The Same Rate As:
			83716 and 85004
83721QW	83721	83880QW	83880
83900	83901 (x2)	83907	87015 (x2)
83908	83898	83909	83904
83914	83904	85576QW	85576
86200	83520	86355	Deleted code 86064
86357	Deleted code 86379	86367	Deleted code 86587
86480	The sum of the rates of 86353 and 83520	86586	Deleted code 86587
86703QW	86703	87209	87207 (x3)
87807QW	87807	87900	87904 (x5)

Laboratory Costs Subject to Reasonable Charge Payment in 2006

For outpatients, the following codes 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 2006 is 2.5 percent.

Manual instructions for determining the reasonable charge payment can be found in the *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 23, Section 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, *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 8, Section 60.3 instructs that payment is made on a reasonable charge basis. 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).

Transmittal 496, Billing for Blood and Blood Products (Change Request (CR) 3681), issued March 4, 2005, provided instructions and established a new HCPCS modifier BL (Special Acquisition of Blood and Blood Products) to better specify the blood product charge in the hospital outpatient setting.

Because blood product services can also be performed in physician offices, independent laboratories, renal dialysis facilities, and other outpatient settings, contractors and shared system maintainers must update their files to accept the

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modifier BL as a valid modifier for Medicare Part B claims. Providers should submit a separate blood product charge for application of the blood deductible (BL modifier) from a blood product charge to which the blood deductible should not apply.

Transmittal 496 and *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 17, Section 231, provides further instructions on billing for blood products using the BL modifier. (See the *Additional Information* section below for CMS web site access to MLN Matters article MM3681, which discusses CR3681.)

Those codes paid on a reasonable charge basis (as qualified by above text) are:

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 in the *Medicare General Information, Eligibility and Entitlement Manual*, Pub. 100-01, Chapter 3, Section 20.5-20.54:

P9010	P011	P9016	P9021	P9022	P9038	P9039
P9040	P9051	P9054	P9056	P9057	P9058	

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 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	86923	86927	86930	86931
86932	86945	86950	86960	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		

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Implementation

The implementation date for the instruction is January 3, 2006.

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.

Information on the blood deductible is available in the *Medicare General Information, Eligibility, and Entitlement Manual*, Pub. 100-01, Chapter 3, Section 20.5-20.54. That manual is available at <http://www.cms.hhs.gov/manuals/downloads/ge101c03.pdf> on the CMS website.

The official instructions issued to the carrier/intermediary regarding this change can be found at <http://www.cms.hhs.gov/transmittals/downloads/R750CP.pdf> on the CMS website.

To review a MLN Matters article about CR3681, go to <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3681.pdf> on the CMS website.

If you have questions, please contact your carrier/intermediary at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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