MLN Matters Number: MM6070 | **Related Change Request (CR) #: 6070**

Related CR Release Date: December 31, 2008 | **Effective Date: January 1, 2009**

Related CR Transmittal #: R1660CP | **Implementation Date: January 5, 2009**

Note: This article was revised on January 2, 2009, to reflect revisions made to CR 6070 on December 31, 2008. The CR was revised to reflect that the annual update for payments based on the clinical laboratory fee schedule is 4.5 percent, as originally stated. However, payments made on a reasonable charge basis for all other laboratory services are updated by 5.0 percent. The CR release date, transmittal number and Web address were also changed.

Calendar Year (CY) 2009 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

Provider Types Affected

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

Impact on Providers

This article is based on Change Request (CR) 6070 which provides instructions for the Calendar Year (CY) 2009 clinical laboratory fee schedule, mapping for new codes for clinical laboratory tests, and updates for laboratory costs subject to the reasonable charge payment.

Background

In accordance with the Social Security Act (Section 1833(h)(2)(A)(i); see http://www.ssa.gov/OP_Home/ssact/title18/1833.htm on the Internet), as amended by the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 (Section 628), the annual update to the local clinical laboratory fee schedule for Calendar Year (CY) 2009

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is 4.5 percent. Payments made on a reasonable charge basis for all other laboratory services is updated by 5.0 percent. The Social Security Act (Section 1833(a)(1)(D)) provides that payment for a clinical laboratory test is the lesser of

- The actual charge billed for the test,
- The local fee, or
- The national limitation amount (NLA).

For a cervical or vaginal smear test (Pap smear), the Social Security Act (Section 1833(h)(7)) 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.

Note: 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), the Social Security Act (Section 1833(h)(7)) 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 2009 national minimum payment amount is $15.42 ($14.76 plus 4.5 percent update for CY 2009). The affected CPT/HCPCS codes for the national minimum payment amount are shown in the following table:

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 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 the Social Security Act (Section 1833(h)(4)(B)(viii)).

Access to Data File

Internet access to the CY 2009 clinical laboratory fee schedule data file is available after November 17, 2008, at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html.](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html) Other interested parties, such as the Medicaid State agencies, the Indian Health Service, the United Mine Workers, and the Railroad Retirement Board, should use the Internet to retrieve the CY 2009 clinical laboratory fee schedule. It will be available in multiple formats: Excel, text, and comma delimited.

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Public Comments

On July 14, 2008, CMS hosted a public meeting to solicit input on the payment relationship between CY 2008 codes and new CY 2009 Current Procedural Terminology (CPT) codes. Notice of the meeting was published in the Federal Register on May 23, 2008, and on the CMS website on June 16, 2008. Recommendations were received from many attendees, including individuals representing laboratories, manufacturers, and medical societies. CMS posted a summary of the meeting and the tentative payment determinations at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html. Additional written comments from the public will be accepted until October 10, 2008. CMS will post a summary of the public comments and the rationale for their final payment determinations on the CMS website also.

Pricing Information

The CY 2009 clinical laboratory fee schedule includes separately payable fees for certain specimen collection methods (CPT/HCPCS codes 36415, P9612, and P9615).

For dates of service from January 1, 2009, through December 31, 2009, the fee for clinical laboratory travel code P9603 is $1.035 per mile (rounded to $1.04 if necessary) and the fee for clinical laboratory travel code P9604 is $10.35 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. If there is a revision to the standard mileage rate for CY 2009, CMS will issue a separate instruction on the clinical laboratory travel fees.

The CY 2009 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 registered with only a certificate of waiver under the Clinical Laboratory Improvement Amendments (CLIA).

Organ or Disease Oriented Panel Codes

Similar to prior years, the CY 2009 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.

Mapping Information

- New code 83876 is priced at the same rate as code 83520.
- New code 83951 is priced by adding the rates for code 83950.
- New code 85397 is priced at the same rate as code 85245.
- New code 87905 is priced by subtracting the rate for code 87176 from the rate for code 82657.
- New code 88720 is priced at the same rate as code 88400.
- New code 88740 is priced at the same rate as code 88400.
- New code 88741 is priced at the same rate as code 88400.
- Code 88400 is deleted beginning CY 2009.

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- Healthcare Common Procedure Coding System (HCPCS) Code G0394 is deleted beginning CY 2009.
- For CY 2009, there are no new test codes to be gap filled.

Laboratory Costs Subject to Reasonable Charge Payment in CY 2009

For outpatients, the following codes are paid under a reasonable charge basis. In accordance with 42 CFR 405.502 through 42 CFR 405.508 (see http://www.access.gpo.gov/nara/cfr/waisidx_01/42cfr405_01.html), 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 prescribed by the Social Security Act (Section 1842(b)(3); see http://www.ssa.gov/OP_Home/ssact/title18/1842.htm) and 42 CFR 405.509(b)(1) (see http://www.access.gpo.gov/nara/cfr/waisidx_01/42cfr405_01.html). Further, Section 145 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) adjusted the inflation-indexed update by -0.5 percent. As a result, the inflation-indexed update for CY 2009 is 4.5 percent.

Manual instructions for determining the reasonable charge payment can be found in Publication 100-04, Medicare Claims Processing Manual (Chapter 23, Section 80 through 80.8; see http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html). 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 (Chapter 8, Section 60.3; see http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html) 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 in the Medicare General Information, Eligibility and Entitlement Manual (Chapter 3, Section 20.5 through 20.54;

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see http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website) (formerly Medicare Carriers Manual (MCM) 2455):

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 the Social Security Act (Section 1842(o)). The payment limits based on that provision, 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				

Additional Information

The official instruction, CR 6070, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1660CP.pdf.

If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html.

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