



Medicare
Learning
Network

**PAYMENT
SYSTEM
FACT SHEET
SERIES**



CMS
CENTERS for MEDICARE & MEDICAID SERVICES



DEPARTMENT OF HEALTH & HUMAN SERVICES · USA



**Clinical
Laboratory
Fee Schedule**



Under Sections 1833 and 1861 of the Social Security Act (the Act), outpatient clinical laboratory services are paid on a fee schedule under Medicare Part B when they are furnished in a Medicare participating laboratory and ordered by a physician or qualified nonphysician practitioner who is treating the patient. Laboratories, physicians, and medical groups must accept assignment, which means that they will be paid the Medicare allowed amount as payment in full for their services.

Clinical laboratory services involve the following types of examination of materials derived from the human



body for the purpose of providing information for the diagnosis, prevention, or treatment of disease or for the assessment of a medical condition:

- Biological;
- Microbiological;
- Serological;
- Chemical;
- Immunohematological;
- Hematological;
- Biophysical;
- Cytological;
- Pathological; or
- Other examination of materials.

COVERAGE OF CLINICAL LABORATORY SERVICES

Clinical laboratory services must meet all applicable requirements of the Clinical Laboratory Improvement Amendments (CLIA) of 1988, which established quality standards for all laboratory testing performed on specimens derived from humans. In addition, clinical laboratory services must be medically reasonable and necessary to the overall diagnosis and treatment of the patient's condition. Laboratories that perform clinical laboratory tests must be certified by the Secretary of the Department of Health and Human Services. To find additional information about the CLIA, visit <http://www.cms.hhs.gov/clia> on the Centers for Medicare & Medicaid Services (CMS) website.

Covered clinical laboratory services are furnished in:

- Hospital laboratories (for outpatient or nonhospital patients);
- Physician office laboratories;
- Independent laboratories;
- Dialysis facility laboratories;
- Nursing facility laboratories; and
- Other institutions.

Medicare does not cover routine screening tests, with the exception of the following preventive screening services:

- Cardiovascular screening blood tests;
- Screening Pap tests;
- Colorectal cancer screening tests;



- Prostate Specific Antigen screening blood tests; and
- Diabetes screening tests.

To find additional information about preventive services, visit <http://www.cms.hhs.gov/PreventionGenInfo/> on the CMS website.

HOW PAYMENT RATES ARE SET

Each Part A/Part B Medicare Administrative Contractor pays for services based on local geographic areas, and the fees are based on charges from laboratories in that geographic area. Payment is the lesser of:

- The amount billed;
- The local fee for a geographic area; or
- A national limitation amount (NLA) for the Healthcare Common Procedure Coding System code.

For tests for which NLAs were established before January 1, 2001, the NLA is 74 percent of the median of all local fee schedule amounts. For tests for which NLAs were 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. Each year new laboratory test codes and corresponding fees are added to the fee schedule. Fees may be updated for inflation based on the percentage change in the Consumer Price Index for All Urban Consumers (CPI-U) as authorized by legislation. For 2004 through 2008, the laboratory fee schedule update was set at 0 percent by Congress. For calendar year (CY) 2009, Congress set the laboratory fee schedule update at the CPI-U minus 0.5 percent or 4.5 percent. A cervical or



vaginal smear test (Pap smear) is paid the lesser of the local fee or the NLA, but not less than a national minimum payment amount. The national minimum payment amount for the cervical or vaginal smear in CY 2009 is \$15.42, which includes the 4.5 percent annual update for CY 2009.

To find additional information about clinical laboratory services and the Clinical Laboratory Fee Schedule, visit <http://www.cms.hhs.gov/center/clinical.asp> and <http://www.cms.hhs.gov/clinlabfeesched> on the CMS website.



This fact sheet was prepared as a service to the public and is not intended to grant rights or impose obligations. This fact sheet may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at <http://www.cms.hhs.gov/MLNGenInfo> on the CMS website.

Medicare Contracting Reform (MCR) Update

In Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) Congress mandated that the Secretary of the Department of Health and Human Services replace the current contracting authority under Title XVIII of the Social Security Act with the new Medicare Administrative Contractor (MAC) authority. This mandate is referred to as Medicare Contracting Reform. Medicare Contracting Reform is intended to improve Medicare's administrative services to beneficiaries and health care providers. All Medicare work performed by Fiscal Intermediaries and Carriers will be replaced by the new A/B MACs by 2011. Providers may access the most current MCR information to determine the impact of these changes and to view the list of current MACs for each jurisdiction at <http://www.cms.hhs.gov/MedicareContractingReform/> on the CMS website.