CLINICAL LABORATORY SERVICES PAYMENT SYSTEM

*payment***basics**

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Medicare is the largest single purchaser of clinical laboratory services. Clinical lab services are tests on specimens taken from the human body (such as blood or urine) and used to help physicians diagnose or assess health. Under Part B, Medicare covers medically necessary diagnostic and monitoring laboratory services that are ordered by a physician when they are provided in a Medicare-participating lab. With a few exceptions, Medicare does not cover routine screening tests unless directed to by law. Under current law, covered screening tests (with some restrictions) include cholesterol and blood lipid tests, fecal occult blood testing, Pap smear tests, prostate-specific antigen tests, and diabetes screening tests.

Clinical lab services are furnished by labs located in hospitals and physician offices, as well as by independent labs. Services may also be furnished by labs located in dialysis facilities, nursing facilities, and other institutions, but frequently these services are covered under other Medicare payment systems.

Repeated reductions in Medicare's payment rates contributed to declining spending for services provided in independent and physician office labs throughout the 1990s. Since 1999, however, growth in volume has caused Medicare expenditures for all lab services to climb an average of 9 percent per year despite the fact that payment rates have been updated only once since 1997. In 2006, Medicare payments for clinical lab services totaled $6.9 billion.

To pay for lab services, Medicare uses 56 carrier-specific fee schedules established in 1984. Payment rates for each test were set separately in each carrier's geographic market, based on what local labs charged in 1983; since then, the rates have been updated periodically for inflation. In addition, there are national payment limits that cap the fee schedule rates for each test. These national limits are set at 74 percent of the median of all carrier fee schedule amounts for each service. In practice, most lab claims are paid at the national limitation amounts.

Defining the product Medicare buys

Medicare sets payment rates for more than 1,100 Healthcare Common Procedure Coding System (HCPCS) codes used in billing for laboratory services. Although in theory there is a separate code for each service, in practice a single HCPCS code may identify more than one testing method for a given substance or more than one substance analyzed by a single method. Panel tests, which are tests commonly ordered together, have their own HCPCS codes as well.

Setting the payment rates

The fee schedule payment rates are the total payment laboratories will receive for their services; there is no beneficiary copayment. Each carrier market has its own fee schedule based upon charges from the laboratories in that market. Fee schedule amounts may therefore differ from carrier to carrier.

Beginning in 1986, the Congress established upper limits on laboratory payment rates, called national limitation amounts (NLAs). NLAs are based on the median of all carrier rates for each test. The NLAs have been repeatedly reduced and currently are set at 74 percent of the median of all local fee schedule amounts for each service. The payment for each service is the lesser of the providers' charge, the carrier's fee schedule amount, or the NLA (Figure 1). In practice, because so many of the carrier payment rates are

This document does not reflect proposed legislation or regulatory actions.

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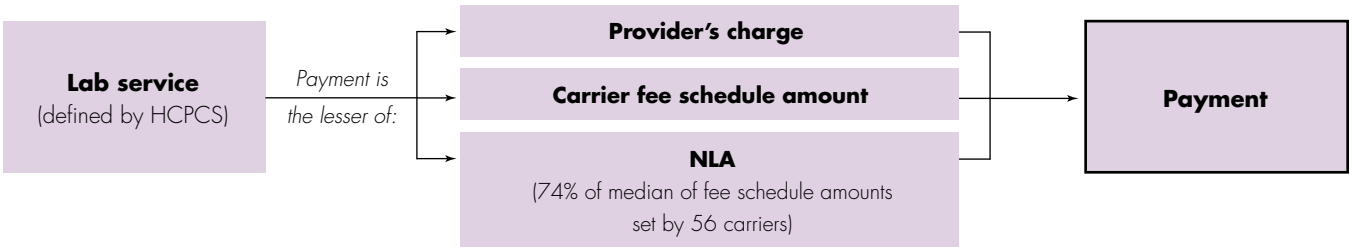
Figure 1 Clinical laboratory services payment system



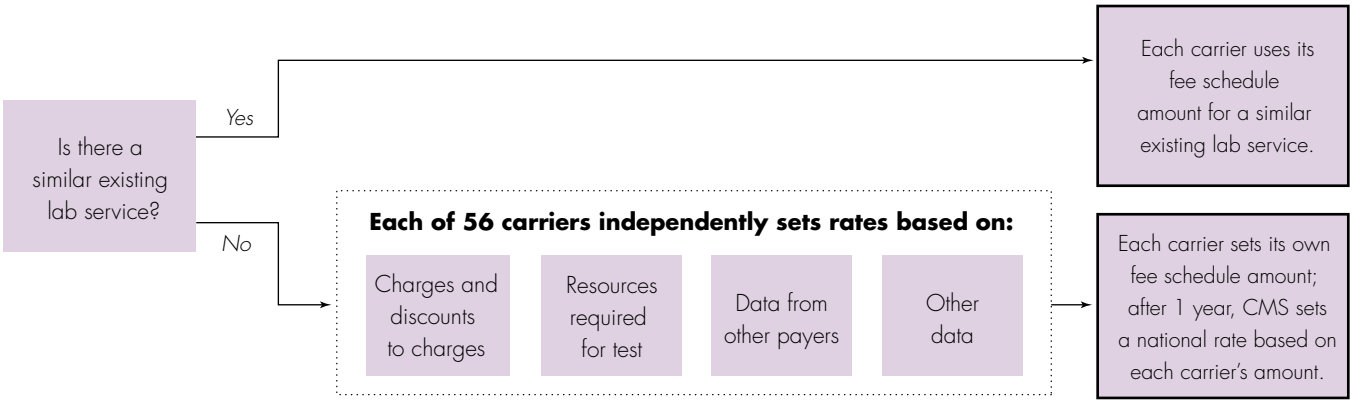
Note: HCPCS (Healthcare Common Procedure Coding System), NLA (national limitation amount). The vast majority of claims are paid at the NLA. Carriers are CMS contractors who are responsible for reviewing and paying providers' Medicare Part B claims.

constrained by the NLAs, most lab services are paid the same national rate.

Initially, lab payments were adjusted for inflation annually using the consumer price index for all urban consumers, but since 1987 the Congress has specified lower update factors or none at all. Payments have been updated only once since 1997.

When newly developed tests are used by laboratories, the Centers for Medicare & Medicaid Services (CMS) uses a "crosswalking" method to assign payment rates based on their similarity to existing tests (Figure 2). For breakthrough technologies for which there are no similar existing tests, CMS relies on a "gapfilling" method in which the carriers independently set rates for the first year of use. Each carrier researches and sets its own payment amount with limited guidance from CMS based on charges for the test and routine discounts to charges, resources required to perform the test, data from other payers, or other information. Once carriers set their payment rates for a new test, the median rate is identified and the NLA is set at 74 percent of that amount. After one year, if CMS determines that the rate assigned to a new test using the gapfilling method is

Figure 2 Setting carrier fee schedule amounts for a new clinical lab service



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inappropriate, CMS may assign a different rate using the crosswalk method. There is no mechanism for reviewing payment rates for existing tests.

There are some exceptions to the fee schedule for clinical laboratory tests furnished on an outpatient basis. For example, critical access hospitals are paid for laboratory tests on a reasonable cost basis, instead of by the fee schedule. In addition, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires the Secretary to conduct a demonstration using competitive bidding for clinical laboratory tests. CMS has designed the demonstration, but has not yet selected the sites. ■