Medicare Learning Network
MLN Matters
CMS
Information for Medicare Fee-for-Service Health Care Professionals

News Flash - Understanding the Remittance Advice: *A Guide for Medicare Providers, Physicians, Suppliers, and Billers* serves as a resource on how to read and understand a Remittance Advice (RA). Inside the guide, you will find useful information on topics such as the types of RAs, the purpose of the RA, and the types of codes that appear on the RA. The *RA Guide* is available as a downloadable document from the Medicare Learning Network Publications web page. To download and view, please go to http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

MLN Matters Number: MM5813
Related Change Request (CR) #: 5813
Related CR Release Date: December 20, 2007
Effective Date: January 1, 2008
Related CR Transmittal #: R1400CP
Implementation Date: January 7, 2008

2008 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).

What Providers Need to Know

This article and related CR5813 contain important information regarding:

- The 2008 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.

Key Points

Updates to Fees

In accordance with Section 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 2008 is 0 percent. 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), Section 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.

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

National Minimum Payment Amounts

The 2008 national minimum payment amount is $14.76 ($14.76 plus 0 percent update for 2008). 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 2008 Clinical Laboratory Fee Schedule

Internet access to the 2008 clinical laboratory fee schedule data file should be available after November 16, 2007, at *http://www.cms.hhs.gov/ClinicalLabFeeSched* on the Centers for Medicare & Medicaid Services (CMS) website.

Medicaid State agencies, the Indian Health Service, the United Mine Workers, Railroad Retirement Board, and other interested parties should use the Internet to retrieve the 2008 clinical laboratory fee schedule. It will be available in multiple formats: Excel, text, and comma delimited.

Public Comments

On July 16, 2007, CMS hosted a public meeting to solicit input on the payment relationship between 2007 codes and new 2008 Current Procedural Terminology codes. Notice of the meeting was published in the Federal Register on May 25, 2007 and on the CMS website on June 18, 2007.

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.hhs.gov/ClinicalLabFeeSched* on the CMS website. Additional written comments from the public were accepted until October 5, 2007.

Comments after the release of the 2008 laboratory fee schedule can be submitted to the following address so that CMS may consider them for the development of the 2009 laboratory fee schedule. 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, 2009 implementation date, comments must be submitted before August 1, 2008.

Centers for Medicare & Medicaid Services (CMS)
Center for Medicare Management
Division of Ambulatory Services
Mailstop: C4-02-14
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Additional Pricing Information

The 2008 laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615).

For dates of service January 1, 2008 through December 31, 2008, 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. If there is a revision to the standard mileage rate for calendar year 2008, CMS will issue a separate instruction on the clinical laboratory travel fees.

The 2008 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 2008 pricing amounts for certain organ or disease panel codes and evocative/suppression test codes were derived by summing the lower of the fee schedule amount or the NLA for each individual test code included in the panel code.

The CPT Editorial Panel has created code 80047 (Basic Metabolic Panel (Calcium, ionized)), which is an automated multi-channel chemistry (AMCC) code.

New code 80047 is not a replacement for code 80048 (Basic metabolic panel). Code 80047 is comprised of eight component test codes, i.e.:

- Calcium, ionized (82330);
- Carbon Dioxide (82374);
- Chloride (82435);
- Creatinine (82565);
- Glucose (82947);
- Potassium (84132);
- Sodium (84295); and
- Urea Nitrogen (BUN) (84520).

Note that 80047 cannot be billed for services ordered through an ESRD facility. All tests billed for services ordered through an ESRD facility must be billed individually, not in an organ disease panel.

Mapping Information

CMS advises the following:

- New code 80047 is priced at the same rate as 80048 with final payment determined by the AMCC Panel Payment Algorithm;
- New code 82310QW is priced at the same rate as 82310;
- New code 82565QW is priced at the same rate as 82565;
- New code 82610 is priced at the same rate as 83883;
- New code 83655QW is priced at the same rate as 83655;
- New code 83993 is priced at the same rate as 83631;
- New code 84704 is priced at the same rate as 84702;
- New code 86356 is priced at the same rate as 86361;
- New code 87500 is priced at the same rate as 87641;
- New code 87809 is priced at the same rate as 87802;
- New code 89321QW is priced at the same rate as 89321;
- New code 89322 is priced at the sum of the rates of 89320 and 85007;
- New code 89331 is priced at the sum of the rates of 89320 and 87015; and
- New AMCC code ATP23 is priced at the same rate as ATP22.

Laboratory Costs Subject to Reasonable Charge Payment in 2008

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 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 §1842(b)(3) of the Act and 42 CFR 405.509(b)(1). The inflation-indexed update for year 2008 is 2.7 percent.

Manual instructions for determining the reasonable charge payment can be found in the *Medicare Claims Processing Manual*, Chapter 23, Section 80-80.8. If there is insufficient charge data for a code, the instructions permit considering charges for other similar services and price lists. The *Medicare Claims Processing Manual* is located at *http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS website.

When these services are performed for independent dialysis facility patients, the *Medicare Claims Processing Manual*, Chapter 8, Section 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	P9043
P9044	P9048	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 20.5-20.54 (located at *http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS website):

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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, and 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

If you have questions, please contact your Medicare Carrier, FI or A/B MAC at their toll-free number which can be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.

To see the official instruction, CR5813, issued to your Medicare FI, Carrier or A/B MAC, go to *http://www.cms.hhs.gov/Transmittals/downloads/R1400CP.pdf* on the CMS website.

Instruction for calculating reasonable charges are located in the Medicare Claims Processing Manual, Chapter 23, Section 80-80.8 at *http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf* on the CMS website.

News Flash - It's seasonal flu time again! If you have Medicare patients who haven't yet received their flu shot, you can help them reduce their risk of contracting the seasonal flu and potential complications by recommending an annual influenza and a one-time pneumococcal vaccination. Medicare provides coverage for flu and pneumococcal vaccines and their administration. – And don't forget to immunize yourself and your staff. Protect yourself, your patients, and your family and friends. Get Your Flu Shot – Not the Flu! Remember - Influenza vaccination is a covered Part B benefit but the influenza vaccine is NOT a Part D covered drug. Health care professionals and their staff can learn more about Medicare's coverage of adult immunizations and related provider education resources, by reviewing Special Edition *MLN Matters* article SE0748 at ***http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0748.pdf*** on the CMS website.