CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1180	**Date: FEBRUARY 2, 2007**
	Change Request 5493

SUBJECT: Outpatient Clinical Laboratory Tests Furnished by Hospitals With Fewer Than 50 Beds in Qualified Rural Areas

I. SUMMARY OF CHANGES: Extension of section 416 of the Medicare Modernization Act for cost reimbursement for outpatient clinical laboratory tests furnished by hospitals with fewer than 50 beds in qualified rural areas.

New / Revised Material
Effective Date: January 1, 2007
Implementation Date: July 2, 2007

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
N/A	

III. FUNDING:
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

One-Time Notification

Unless otherwise specified, the effective date is the date of service.

Attachment – One-Time Notification

Pub. 100-04	Transmittal: 1180	Date: February 2, 2007	Change Request: 5493

SUBJECT: Outpatient Clinical Laboratory Tests Furnished by Hospitals With Fewer Than 50 Beds in Qualified Rural Areas

Effective Date: January 1, 2007

Implementation Date: July 2, 2007

I. GENERAL INFORMATION

A. Background: Medicare outpatient covered clinical laboratory services are generally paid based on a fee schedule. Medicare beneficiaries are not liable for coinsurance and deductible for clinical laboratory services. For critical access hospitals (CAHs), the Balanced Budget Refinement Act of 1999 provided payment on a reasonable cost basis for outpatient clinical laboratory tests. Section 416 of the Medicare Modernization Act (MMA) of 2003 added payment on a reasonable cost basis for outpatient clinical laboratory tests to hospitals with fewer than 50 beds in qualified rural areas for cost reporting periods beginning during the 2-year period beginning on July 1, 2004, per the implementation of CR 3130. Recently, section 105 of the Tax Relief and Health Care Act of 2006 extended the provision of section 416 of the MMA for an additional year, or cost reporting periods beginning during the **3**-year period beginning on July 1, 2004.

B. Policy: Payment for outpatient clinical laboratory tests will be made by reasonable costs for a hospital with 50 beds in qualified rural areas for cost reporting periods beginning during the 3-year period beginning on July 1, 2004. Also for these services, Medicare beneficiaries are not liable for coinsurance, deductibles or other cost sharing amount. A qualified rural area is one with a population density in the lowest quartile of all rural county populations. The reasonable costs are determined using the ratio of costs to charges for the laboratory cost center multiplied by the Provider Statistical and Reimbursement's Report (PS&R's) billed charges for outpatient laboratory services for cost reporting periods beginning on or after July 1, 2004 but before July 1, 2007. The same rules that are used to determine whether clinical laboratory services are furnished as an outpatient CAH service apply for outpatient clinical laboratory tests to hospitals with fewer than 50 beds in qualified rural areas. Condition of participation for hospitals 42 CFR §485.620(a) and State Operations Manual, Appendix W §485.62(a) establish the rules for bed count for CAHs.

Identification of Qualified Rural Areas

The Centers for Medicare & Medicaid Services (CMS) central office identifies the lowest quartile population density areas in the Medicare zip code file which intermediaries download from the CMS mainframe. For cost reporting periods beginning July 1, 2004, intermediaries populate the special payment indicator on the Outpatient Provider Specific File (OPSF), with an indicator of "1" for qualifying rural areas.

II. BUSINESS REQUIREMENTS

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5493.1	Contractors shall utilize the Medicare zip code file to identify qualified rural areas. Change Request 5394 issued instructions for the Medicare zip code file.	X		X				X				
5493.2	Contractors shall update the OPSF with an indicator of "1" to identify those hospitals in a qualified rural area (i.e. located in the lowest quartile population density) with less than 50 beds, which previously were removed due to the sun-setting provisions stated in CR 3130. Bed count should comply with the condition of participation at 42 CFR §485.620(a) and State Operations Manual, Appendix W §485.62(a).	X		X				X				
5493.3	Contractors shall calculate payment on a reasonable cost basis for outpatient clinical laboratory services for hospitals in a qualified rural area with less than 50 beds during cost report periods beginning on or after July 1, 2004 but before July 1, 2007.	X		X				X				
5493.4	Contractors shall apply requirements 5493.1 and 5493.2 to bill types 12X, and 13X. The contractor shall use revenue code 030X, (laboratory charges for clinical laboratory tests) for each bill type.	X		X				X				
5493.5	Contractors shall not hold the beneficiary liable for any deductible, coinsurance, co-payment or other cost sharing amount.	X		X				X				
5493.6	Contractors shall adjust any affected	X		X				X				

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	laboratory claims (containing lines with revenue code 030X) from hospitals meeting the criteria outlined in 5493.3 above, after updating the OPSF.											

III. PROVIDER EDUCATION

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5493.7	A provider education article related to this instruction will be available at www.cms.hhs.gov/MLNMattersArticles shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.											

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

V. CONTACTS

Pre-Implementation Contact(s): Coverage: Anita Greenberg anita.greenberg@cms.hhs.gov, Hospital Claim Processing: Valeri Ritter valeri.ritter@cms.hhs.gov

Post-Implementation Contact(s): Regional Office

VI. FUNDING

A. *For TITLE XVIII Contractors*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. *For Medicare Administrative Contractors (MAC)*:

The contractor is hereby advised that this constitutes technical direction as defined in your contract. We do not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.