DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

MLN Matters® Number: MM9909 **Related Change Request (CR) #: CR 9909**

Related CR Release Date: December 29, 2016 **Effective Date: January 1, 2017**

Related CR Transmittal #: R3687CP **Implementation Date: January 3, 2017**

Calendar Year (CY) 2017 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

Provider Types Affected

This MLN Matters® Article is intended for clinical diagnostic laboratories submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9909 provides instructions for the Calendar Year (CY) 2017 clinical laboratory fee schedule, mapping for new codes for clinical laboratory tests, and updates for laboratory costs subject to the reasonable charge payment. This update applies to Chapter 16, Section 20 of the "Medicare Claims Processing Manual."

Background

In accordance with Section 1833(h)(2)(A)(i) of the Social Security Act (the Act), the annual update to the local clinical laboratory fees for CY 2017 is 0.70 percent. The annual update to payments made on a reasonable charge basis for all other laboratory services for CY 2017 is 1.00 percent (See 42 CFR 405.509(b)(1)).

Section 1833(a)(1)(D) of the Act 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). The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

Key Points of CR9909

National Minimum Payment Amounts

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 (described below). However, for a cervical or vaginal smear test (pap smear), payment may also not exceed the actual charge.

The CY 2017 national minimum payment amount is $14.49 ($14.39 times 0.70 percent update for CY 2017). The affected codes for the national minimum payment amount are 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88164, 88165, 88166, 88167, 88174, 88175, G0123, G0143, G0144, G0145, G0147, G0148, G0476, and 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 Section 1833(h)(4)(B)(viii) of the Act.

Access to Data File

Internet access to the CY 2017 clinical laboratory fee schedule data file will be available at **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 2017 clinical laboratory fee schedule. It will be available in multiple formats: Excel, text, and comma delimited.

Data File Format

For each test code, if your system retains only the pricing amount, load the data from the field named “60% Pricing Amt.” For each test code, if your system has been developed to retain the local fee and the NLA, you may load the data from the fields named “60% Local Fee Amt” and “60% Natl Limit Amt” to determine payment. For test codes for cervical or vaginal smears (pap smears), you should load the data from the field named “60% Pricing Amt” which reflects the lower of the local fee or the NLA, but not less than the national minimum payment amount. MACs should use the field “62% Pricing Amt” for payment to qualified laboratories of sole community hospitals.

Public Comments and Final Payment Determinations

On July 18, 2016, the Centers for Medicare & Medicaid Services (CMS) hosted a public meeting to solicit input on payment methods for reconsidered CY 2016 codes and new CY 2017 codes. Notice of the meeting was published in the Federal Register on May 13, 2016 and on the CMS web site on approximately May 18, 2016. 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 were accepted until October 31, 2016. CMS has posted a summary of the public comments and the rationale for the final payment determinations at **https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/CY2017-CLFS-Codes-Final-Determinations.pdf.**

Pricing Information

The CY 2017 clinical laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615). The fees have been established in accordance with Section 1833(h)(4)(B) of the Act.

The fees for clinical laboratory travel codes P9603 and P9604 are updated on an annual 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 2017, CMS will issue a separate instruction on the clinical laboratory travel fees.

The CY 2017 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 having only a certificate of waiver under the Clinical Laboratory Improvement Amendments (CLIA).

Organ or Disease Oriented Panel Codes

Similar to prior years, the CY 2017 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. The NLA field on the data file is zero-filled.

Mapping Information

New codes:

- G0659 is priced at the same rate as code G0479.
- 80305 is priced at the same rate as code G0477.
- 80306 is priced at the same rate as code G0478.
- 80307 is priced at the same rate as code G0479.
- 81327 is priced at the same rate as code 81287.
- 81413 is priced at the same rate as code 81435.
- 81414 is priced at the same rate as code 81436.
- 81422 is priced at the same rate as code 81436.
- 81439 is priced at the same rate as code 81435.
- 81539 is priced at the same rate as code 0010M
- 84410 is priced at the same rate as the sum of codes 84402 and 84403
- 87483 is priced at the same rate as code 87633.
- 87338QW is priced at the same rate as code 87338.
- 87631QW is priced at the same rate as code 87631.

Existing Codes:

- 81420 is priced at the same rate as code 81435.
- G0475 is priced at the same rate as code 87389.
- G0476 is priced at the same rate as code 87624.
- G0480 is priced at the same rate as 4.75 times code 82542.
- G0481 is priced at the same rate as 6.50 times code 82542.
- G0482 is priced at the same rate as 8.25 times code 82542.
- G0483 is priced at the same rate as 10.25 times code 82542.
- G0477, G0478, G0479, 0010M, and 82272QW are all to be deleted.

Laboratory Costs Subject to Reasonable Charge Payment in CY 2017

For outpatients, the following codes are paid under a reasonable charge basis (See Section 1842(b)(3) of the Act). In accordance with 42 CFR 405.502 through 42 CFR 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 set forth in 42 CFR 405.509(b)(1). The inflation-indexed update for CY 2017 is 1.0 percent.

Chapter 23, Sections 80 through 80.8 of the "Medicare Claims Processing Manual" contains instructions for determining the reasonable charge payment. If there is sufficient charge data for a code, the instructions permit considering charges for other similar services and price lists.

When services described by the HCPCS in the following list are performed for independent dialysis facility patients, Chapter 8, Section 60.3 of the "Medicare Claims Processing Manual" 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).

Note: Reasonable charge codes P9070, P9071, P9072 and 89337 may be included in the next calendar year's reasonable charge update.

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
P9070	P9071	P9072	

Also, payment for the following codes should be applied to the blood deductible as instructed in Chapter 3, Sections 20.5 through 20.5.4 of the "Medicare General Information, Eligibility and Entitlement Manual."

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 Section 1842(o) of the Act. The payment limits based on Section 1842(o), including the payment limits for codes P9041, P9045, P9046, and P9047, should be obtained from the Medicare Part B drug pricing files.

Transfusion Medicine

86850	86860	86870	86880
86885	86886	86890	86891
86900	86901	86902	86904
86905	86906	86920	86921
86922	86923	86927	86930
86931	86932	86945	86950
86960	86965	86970	86971
86972	86975	86976	86977
86978	86985		

Reproductive Medicine Procedures

89250	89251	89253	89254
89255	89257	89258	89259
89260	89261	89264	89268
89272	89280	89281	89290
89291	89335	89337	89342
89343	89344	89346	89352
89353	89354	89356	

Additional Information

The official instruction, CR9909 issued to your MAC regarding this change is available at **https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3687CP.pdf**.

If you have any questions, please contact your MAC at their toll-free number. That number is available at **https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/**.