CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 100 **Date: FEBRUARY 13, 2004**

CHANGE REQUEST 3130

The APASS maintainer and associated FIs are waived from implementing this requirement on July 6, 2004, due to their upcoming transition to the FISS system. However, they must implement this requirement upon transitioning to the FISS system.

I. SUMMARY OF CHANGES: This change implement procedures for payment of Outpatient Clinical Laboratory Tests Furnished by 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.

NEW/REVISED MATERIAL - EFFECTIVE DATE: July 1, 2004
***IMPLEMENTATION DATE: July 6, 2004**

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

II. SCHEDULE OF CHANGES (R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	16/40/3 Hospital Billing Under Part B

III. FUNDING: *Medicare contractors only:

These instructions should be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification

Attachment - Business Requirements

Pub. 100-04	Transmittal: 100	Date: February 13, 2004	Change Request 3130

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

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 any coinsurance and deductible. Instructions for the calendar year 2004 Medicare clinical laboratory fee schedule were issued in Pub. 100-20, Transmittal 20, Change Request 2959, 2004 Annual Update for Clinical Laboratory Fee Schedule and Pub. 100-20, Transmittal 31, Change Request 3013, Emergency Revised 2004 Update of the DMEPOS and Clinical Laboratory Fee Schedules.

After the enactment of Balanced Budget Refinement Act of 1999 outpatient clinical laboratory tests furnished by Critical Access Hospitals (CAHs) are not paid based on a fee schedule but instead are paid on a reasonable cost basis. Also for these services, Medicare beneficiaries are not liable for any coinsurance, deductible, co-payment, or other cost sharing amount. The effective date of this change was November 29, 1999 and the implementation date was July 1, 2001 as described in Program Memorandum A-01-31, Change Request 1568.

B. Policy:

Section 416 of the Medicare Prescription, Drug, Improvement, and Modernization Act (MMA) of 2003 also eliminates the application of the clinical laboratory fee schedule for hospital outpatient laboratory testing by a hospital laboratory with fewer than 50 beds in a qualified rural area for cost reporting periods beginning during the 2-year period beginning on July 1, 2004. Payment for these hospital outpatient laboratory tests will be reasonable costs without coinsurance and deductibles during the applicable time period. 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 PS&R's billed charges for outpatient laboratory services for cost reporting periods beginning on or after July 1, 2004 but before July 1, 2006.

In determining whether clinical laboratory services are furnished as part of outpatient services of a hospital, the same rules that are used to determine whether clinical laboratory services are furnished, as an outpatient critical access hospital service will apply.

Type of bill 12X, 13X and 85x will continue to use revenue code 030X, laboratory charges for performance of diagnostic and routine clinical lab tests.

Identification of Qualified Rural Areas

The Centers for Medicare & Medicaid Services (CMS) central office will determine the qualified rural areas and will identify the lowest 25% quartile population density areas. A file of the eligible zip codes will be available for the intermediaries to download from the CMS mainframe on or about May 15, 2004.

For cost reporting periods beginning July 1, 2004, intermediaries will populate the new special locality indicator on the provider specific file identifying rural areas with an indicator of "1".

C. Provider Education:

A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article to their Web site, and include it in a listserv message if applicable, within one week of the availability of the provider education article.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
3130.1	The shared systems maintainer shall modify the provider specific file to include a new alphanumeric field in position 138 titled "Special Locality Indicator".	SSM
3130.2	The FI shall download the appropriate file from the CMS mainframe identifying the eligible zip codes for cost reimbursement.	FIs
3130.2.1	The FI shall update the provider specific file, position 138, with an indicator of "1" to identify those hospitals in a qualified rural area with less than 50 beds as identified in requirement 3130.2.	FIs
3130.3	The FI shall calculate payment for these hospitals in a qualified rural area with <50 beds on a reasonable cost basis for services paid during cost report periods beginning on or after July 1, 2004 but before July 1, 2006.	SSM FIs
3130.3.1	The FI shall not hold the beneficiary liable for any deductible, coinsurance, co-payment or other cost sharing amount.	SSM FIs
3130.4	The FI shall apply the above rules to bill types 12X, 13X, and 85X.	FIs

3130.4.1	The FI shall continue to use revenue code 030X, (laboratory charges for performance of diagnostic and routine clinical lab tests) for each bill type.	FIs

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: July 1, 2004 **Implementation Date: July 6, 2004** **Pre-Implementation Contact(s): Linda Easter (410) 786-6978** **Post-Implementation Contact(s): Linda Easter (410) 786-6978**	**These instructions shall be implemented within your current operating budget**

40.3 - Hospital Billing Under Part B

(Rev. 100, 02-13-04)

HO-437, A3-3628

Hospital laboratories, billing for either outpatient or nonpatient claims, bill the FI. Neither deductible nor coinsurance applies to laboratory tests paid under the fee schedule.

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Hospitals must follow requirements for submission of the Form CMS-1450 (see Chapter 25 for billing requirements).

When the hospital obtains laboratory tests for outpatients under arrangements with clinical laboratories or other hospital laboratories, only the hospital can bill for the arranged services.

If all tests are for a nonpatient, the hospital may submit one bill and be reimbursed at 60 percent. If the hospital is a sole community hospital identified in the PPS Provider Specific File with a qualified hospital laboratory identified on the hospital's certification; tests for outpatients are reimbursable at 62 percent. If tests are for an outpatient, those referred to a reference laboratory are considered nonpatient tests reimbursable at 60 percent.

If the hospital bills for both types of outpatient tests, it should prepare two bills: one for its own laboratory tests reimbursable at 62 percent, the other for the tests referred to the reference laboratory reimbursable at 60 percent. The CMS-1450 (UB-92) Type of Bill (TOB) code (FL4) for the nonpatient bill is 14X. The hospital includes fee schedule laboratory tests on the same bill with other outpatient services to the same beneficiary on the same day, unless it is billing for a reference laboratory as described above, in which case it submits a separate bill for the reference laboratory tests. Hospitals should not submit separate bills for laboratory tests performed in different departments on the same day.

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