CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3071	**Date: September 19, 2014**
	Change Request 8883

SUBJECT: Manual Update to Clarify Claims Processing for Laboratory Services

I. SUMMARY OF CHANGES: The purpose of this CR is to update the Medicare manual to clarify key components of claims processing for Laboratory Services. These changes are intended only to clarify the existing policies and no system or processing changes are anticipated. The updated manual and section are as follows: Pub.100-04, Medicare Claims Processing Manual, chapter 16.

EFFECTIVE DATE: December 22, 2014
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: December 22, 2014

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
R	16 /50.5 /Jurisdiction of Laboratory Claims
R	16 /60.1.2 / Independent Laboratory Specimen Drawing
R	16 /60.2/Travel Allowance

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted 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.

IV. ATTACHMENTS:
Business Requirements
Manual Instruction

Attachment - Business Requirements

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I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to update the Medicare manual to clarify the claims billing jurisdiction for the laboratory specimen collection fee and travel allowance.

B. Policy: This CR communicates revisions to the Laboratory Services chapter of the Medicare Claims Processing Manual (Publication 100-04, Chapter 16) so that billing and claims processing instructions contained within are up-to-date with regards to billing for the laboratory services furnished by an independent laboratory. The update clarifies that the location where the independent laboratory performed the test determines the appropriate billing jurisdiction for specimen collection fees and travel allowance. Contractors shall be in compliance with the instructions found in these chapters.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8883.1	Contractors shall be in compliance with the instructions found in the CMS Internet Only Manual (IOM) Publication 100-04, Chapter 16-Laboratory Services, Sections 50.5, 60.1.2 and 60.2.	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
8883.2	MLN Article : A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will	X	X		X	

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	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 sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. 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

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Teira Canty, teira.canty@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted 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.

ATTACHMENTS: 0

50.5 - Jurisdiction of Laboratory Claims

(Rev.3071, Issued: 09-19-14, Effective: 12-22-14, Implementation: 12-22-14)

Jurisdiction of payment requests for laboratory services furnished by an independent laboratory, except where indicated in §50.5.1 and §50.5.2, lies with the *B MAC* serving the area in which the laboratory test is performed. Jurisdiction is not affected by whether or not the independent laboratory uses a central billing office and whether or not the laboratory provides services to customers outside its carrier's service area. The *location where the independent laboratory performed the test determines the appropriate billing jurisdiction. Therefore, even if the sample originates in a different jurisdiction from where the sample is being tested, the claim would still be filed in the jurisdiction where the test was performed.*

Claims filing jurisdiction for the specimen collection fee and travel allowance is also determined by the location where the test was performed. When billed by an independent lab, the specimen collection fee and travel allowance must be billed in conjunction with a covered lab test. For more information about the specimen collection fee and travel allowance, see §60.1 and §60.2, respectively.

60.1.2 - Independent Laboratory Specimen Drawing

Rev.3071, Issued: 09-19-14, Effective: 12-22-14, Implementation: 12-22-14)

Medicare allows separate charges made by laboratories for drawing or collecting specimens whether or not the specimens are referred to hospitals or independent laboratories. The laboratory does not bill for routine handling charges where a specimen is referred by one laboratory to another.

Medicare allows *payment for* a specimen collection fee when it is medically necessary for a laboratory technician to draw a specimen from either a nursing home patient or homebound patient. *Payment for the specimen collection fee is made based on the clinical laboratory fee schedule.* The technician must personally draw the specimen, e.g., venipuncture or urine sample by catheterization. Medicare does not allow a specimen collection fee to the visiting technician if a patient in a facility is (a) not confined to the facility, or (b) the facility has personnel on duty qualified to perform the specimen collection. Medical necessity for such services exists, for example, where a laboratory technician draws a blood specimen from a homebound or an institutionalized patient. A patient need not be bedridden to be homebound. However, where the specimen is a type that would require only the services of a messenger and would not require the skills of a laboratory technician, e.g., urine or sputum, a specimen pickup service would not be considered medically necessary. (See Chapters 7 and 15 of the Medicare Benefit Policy Manual for a discussion of "homebound" and a more complete definition of a medically necessary laboratory service to a homebound or an institutional patient.)

In addition to the usual information required on claim forms (including the name of the prescribing physician), all independent laboratory claims for such specimen drawing or EKG services prescribed by a physician should be appropriately annotated, e.g., "patient confined to home," "patient homebound," or "patient in nursing home, no qualified person on duty to draw specimen." Carriers must assure the validity of the annotation through scientific claims samples as well as through regular bill review techniques. (This could be done by use of the information in carrier files, and where necessary, contact with the prescribing physician.)

If a physician requests an independent laboratory to obtain specimens in situations which do not meet, or without regard to whether they meet, the medical necessity criteria in Chapter 15 of the Medicare Benefit Policy Manual, an educational contact with the prescribing physician is warranted and, where necessary, corroborating documentation should be obtained on claims until the carrier is assured that the physician prescribes such services only when the criteria are met.

The specimen collection fee is paid based on the location of the independent laboratory where the test is performed and is billed in conjunction with a covered laboratory test.

60.2 - Travel Allowance

Rev.3071, Issued: 09-19-14, Effective: 12-22-14, Implementation: 12-22-14)

In addition to a specimen collection fee allowed under §60.1, Medicare, under Part B, covers a specimen collection fee and travel allowance for a laboratory technician to draw a specimen from either a nursing home patient or homebound patient under §1833(h)(3) of the Act and payment is made based on the clinical laboratory fee schedule. The travel allowance is intended to cover the estimated travel costs of collecting a specimen and to reflect the technician's salary and travel costs.

The additional allowance can be made only where a specimen collection fee is also payable, i.e., no travel allowance is made where the technician merely performs a messenger service to pick up a specimen drawn by a physician or nursing home personnel. The travel allowance may not be paid to a physician unless the trip to the home, or to the nursing home was solely for the purpose of drawing a specimen. Otherwise travel costs are considered to be associated with the other purposes of the trip.

Claims filing jurisdiction for the travel allowance and collection fees is based on the location where the test was performed.

The travel allowance is not distributed by CMS. Instead, the carrier must calculate the travel allowance for each claim using the following rules for the particular Code. The following HCPCS codes are used for travel allowances:

Per Mile Travel Allowance (P9603)

- The minimum "per mile travel allowance" is $1.01. The per mile travel allowance is to be used in situations where the average trip to patients' homes is longer than 20 miles round trip, and is to be pro-rated in situations where specimens are drawn or picked up from non-Medicare patients in the same trip. - one way, in connection with medically necessary laboratory specimen collection drawn from homebound or nursing home bound patient; prorated miles actually traveled (carrier allowance on per mile basis); or

- The per mile allowance was computed using the Federal mileage rate plus an additional 45 cents a mile to cover the technician's time and travel costs. Contractors have the option of establishing a higher per mile rate in excess of the minimum ($1.01 a mile in CY 2014) if local conditions warrant it. The minimum mileage rate will be reviewed and updated in conjunction with the clinical lab fee schedule as needed. At no time will the laboratory be allowed to bill for more miles than are reasonable or for miles not actually traveled by the laboratory technician.

Example 1: In CY 2014, a laboratory technician travels 60 miles round trip from a lab in a city to a remote rural location, and back to the lab to draw a single Medicare patient's blood. The total reimbursement would be $60.60 (60 miles x $1.01 cents a mile), plus the specimen collection fee.

Example 2: In CY 2014, a laboratory technician travels 40 miles from the lab to a Medicare patient's home to draw blood, and then travels an additional 10 miles to a non-Medicare patient's home and then travels 30 miles to return to the lab. The total miles traveled would be 80 miles. The claim submitted would be for one half of the miles traveled or $40.40 (40 x $1.01), plus the specimen collection fee.

Flat Rate (P9604)

The CMS will pay a minimum of $10.10 one way flat rate travel allowance. The flat rate travel allowance is to be used in areas where average trips are less than 20 miles round trip. The flat rate travel fee is to be pro-rated for more than one blood drawn at the same address, and for stops at the homes of Medicare and non-

Medicare patients. The laboratory does the pro-ration when the claim is submitted based on the number of patients seen on that trip. The specimen collection fee will be paid for each patient encounter.

This rate is based on an assumption that a trip is an average of 15 minutes and up to 10 miles one way. It uses the Federal mileage rate and a laboratory technician's time of $17.66 an hour, including overhead. Contractors have the option of establishing a flat rate in excess of the minimum of $10.10, if local conditions warrant it. The minimum national flat rate will be reviewed and updated in conjunction with the clinical laboratory fee schedule, as necessitated by adjustments in the Federal travel allowance and salaries.

The claimant identifies round trip travel by use of the LR modifier

Example 3: A laboratory technician travels from the laboratory to a single Medicare patient's home and returns to the laboratory without making any other stops. The flat rate would be calculated as follows: 2 x $10.10 for a total trip reimbursement of $20.20, plus the specimen collection fee.

Example 4: A laboratory technician travels from the laboratory to the homes of five patients to draw blood, four of the patients are Medicare patients and one is not. An additional flat rate would be charged to cover the 5 stops and the return trip to the lab (6 x $10.10 = $60.60). Each of the claims submitted would be for $12.12 ($60.60/5 = $12.12). Since one of the patients is non-Medicare, four claims would be submitted for $12.12 each, plus the specimen collection fee for each.

Example 5: A laboratory technician travels from a laboratory to a nursing home and draws blood from 5 patients and returns to the laboratory. Four of the patients are on Medicare and one is not. The $10.10 flat rate is multiplied by two to cover the return trip to the laboratory (2 x $10.10 = $20.20) and then divided by five (1/5 of $20.20 = $4.04). Since one of the patients is non-Medicare, four claims would be submitted for $4.04 each, plus the specimen collection fee.

If a carrier determines that it results in equitable payment, the carrier may extend the former payment allowances for additional travel (such as to a distant rural nursing home) to all circumstances where travel is required. This might be appropriate, for example, if the carrier's former payment allowance was on a per mile basis. Otherwise, it should establish an appropriate allowance and inform the suppliers in its service area. If a carrier decides to establish a new allowance, one method is to consider developing a travel allowance consisting of:

- The current Federal mileage allowance for operating personal automobiles, plus a personnel allowance per mile to cover personnel costs based upon an estimate of average hourly wages and average driving speed.

Carriers must prorate travel allowance amounts claimed by suppliers by the number of patients (including Medicare and non-Medicare patients) from whom specimens were drawn on a given trip.

The carrier may determine that payment in addition to the routine travel allowance determined under this section is appropriate if:

- The patient from whom the specimen must be collected is in a nursing home or is homebound; and

- The clinical laboratory tests are needed on an emergency basis outside the general business hours of the laboratory making the collection.

- Subsequent updated travel allowance amounts will be issued by CMS via Recurring Update Notification (RUN) on an annual basis.