

Key to Medicare Status Indicators

The following Medicare status indicators apply to clinical diagnostic laboratory test codes (Healthcare Common Procedure Coding System (HCPCS) codes) for the January 1, 2016 through June 30, 2016 data collection period. The indicator for a test code specifies how Medicare treats the test code for payment purposes for the calendar year (CY) 2016 Clinical Laboratory Fee Schedule (CLFS).

Contractor Priced: Medicare Administrative Contractors (MACs) established local payment amounts for the test code using gapfilling methodologies. Under gapfilling, the MACs use the following sources of information, if available: (1) charges for the test and routine discounts to charges; (2) resources required to perform the test; (3) payment amounts determined by other payors; and (4) charges, payment amounts, and resources required for other tests that may be comparable or otherwise relevant.

NLA: The test code is paid the lesser of (1) the billed amount, (2) the local fee schedule amount established by the MAC, or (3) a National Limitation Amount (NLA), which is a percentage of the median of all the local fee schedule amounts (or 100 percent of the median for new tests furnished on or after January 1, 2001).

Use Another Code/Use Other Codes: The test code is subject to the data collection and reporting requirements for the private payor rate based payment system but the test code is not payable on the CY 2016 CLFS. Instead, for purposes of billing Medicare Part B, a laboratory must use another comparable HCPCS code(s) payable under the CY 2016 CLFS. For example, HCPCS code 80050 (“General health panel”) is not payable under the CY 2016 CLFS. However, each component test included in the descriptor for 80050 has a separate HCPCS code and is payable under the CLFS.