CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 79 **Date: FEBRUARY 6, 2004**

CHANGE REQUEST 2813

I. SUMMARY OF CHANGES: This change will implement procedures to enforce compliance with the payment policy for ESRD-related lab services and respond to payment vulnerabilities identified by the OIG.

NEW/REVISED MATERIAL - EFFECTIVE DATE: Partial Implementation July 1, 2004

***IMPLEMENTATION DATE: Partial Implementation 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	16/40.6.1/ Automated Multi-Channel Chemistry (AMCC) Tests for ESRD Beneficiaries

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 Special Notification

ESRD COMPOSITE RATE TESTS
NON-CAPD
Chemistry Tests

	Chemistry	CPT Code	Monthly	Weekly	13 X quarter
1	Albumin	82040	X		
2	Alkaline phosphatase	84075	X		
3	ALT (SGPT)	84460			
4	AST (SGOT)	84450	X		
5	Bilirubin, total	82247			
6	Bilirubin, direct	82248			
7	Calcium	82310	X		
8	Chloride	82435	X		
9	Cholesterol	82465			
10	CK, CPK	82550			
11	CO2 (bicarbonate)	82374	X		
12	Creatinine	82565		X	
13	GGT	82977			
14	Glucose	82947			
15	LDH	83615	X		
16	Phosphorus	84100	X		
17	Potassium	84132	X		
18	Protein, total	84155	X		
19	Sodium	84295			
20	Triglycerides	84478			
21	Urea nitrogen (BUN)	84520			X
22	Uric Acid	84550			

= non-composite rate test

= composite rate test

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non-composite rate test

composite rate test

40.6.1 – Automated Multi-Channel Chemistry (AMCC) Tests for ESRD Beneficiaries

(Rev. 79, 02-06-04)

A-03-033

Medicare will apply the following rules to Automated Multi-Channel Chemistry (AMCC) tests for ESRD beneficiaries:

- Payment is at the lowest rate for test performed by the same provider, for the same beneficiary, for the same date of service.

- The facility must identify, for a particular date of service, the AMCC tests ordered that are included in the composite rate and those that are not included. See Chapter 8 for the composite rate tests for Hemodialysis, Intermittent Peritoneal Dialysis (IPD), Continuous Cycling Peritoneal Dialysis (CCPD), Hemofiltration, and Continuous Ambulatory Peritoneal Dialysis (CAPD).

- If 50 percent or more of the covered tests are included under the composite rate payment, then all submitted tests are included within the composite payment. In this case, no separate payment in addition to the composite rate is made for any of the separately billable tests.

- If less than 50 percent of the covered tests are composite rate tests, all AMCC tests submitted for that Date of Service (DOS) for that beneficiary are separately payable.

- A noncomposite rate test is defined as any test separately payable outside of the composite rate or beyond the normal frequency covered under the composite rate that is reasonable and necessary.

- *For carrier processed claims, all chemistries ordered for beneficiaries with chronic dialysis for ESRD must be billed individually and must be rejected when billed as a panel.*

(See §100.6 for details regarding pricing modifiers.)

Implementation of this Policy:

ESRD facilities when ordering an ESRD-related AMCC must specify for each test within the AMCC whether the test:

a. Is part of the composite rate and not separately payable;

b. Is a composite rate test but is, on the date of the order, beyond the frequency covered under the composite rate and thus separately payable; or

c. Is not part of the ESRD composite rate and thus separately payable.

Laboratories must:

a. Identify which tests, if any, are not included within the ESRD facility composite rate payment

b. Identify which tests ordered for chronic dialysis for ESRD as follows:

1) Modifier CD: AMCC Test has been ordered by an ESRD facility or MCP physician that is part of the composite rate and is not separately billable.

2) Modifier CE: AMCC Test has been ordered by an ESRD facility or MCP physician that is a composite rate test but is beyond the normal frequency covered under the rate and is separately reimbursable based on medical necessity.

3) Modifier CF: AMCC Test has been ordered by an ESRD facility or MCP physician that is not part of the composite rate and is separately billable.

c. Bill all tests ordered for a chronic dialysis ESRD beneficiary individually and not as a panel.

The shared system must calculate the number of AMCC tests provided for any given date of service. Sum all AMCC tests with a CD modifier and divide the sum of all tests with a CD, CE, and CF modifier for the same beneficiary and provider for any given date of service.

If the result of the calculation for a date of service is 50 percent or greater, do not pay for the tests.

If the result of the calculation for a date of service is less than 50 percent, pay for all of the tests.

For FI processed claims, all tests for a date of service must be billed on the monthly ESRD bill. Providers that submit claims to a FI, must send in an adjustment if they identify additional tests that have not been billed.

Carrier standard systems shall adjust the previous claim when the incoming claim for a date of service is compared to a claim on history and the action is adjust payment. Carrier standard systems shall spread the payment amount over each line item on both claims (the claim on history and the incoming claim).

The organ and disease oriented panels (80048, 80051, 80053, and 80076) are subject to the 50 percent rule. However, clinical diagnostic laboratories shall not bill these services as panels, they must be billed individually. Laboratory tests that are not covered under the composite rate and that are furnished to CAPD end stage renal disease (ESRD) patients dialyzing at home are billed in the same way as any other test furnished home patients.

FI Business Requirements for ESRD Reimbursement of AMCC Tests:

Requirement Number	Requirements	Responsibility
1.1	The FI shared system must RTP a claim for AMCC tests when a claim for that date of service has already been submitted.	Shared system
1.2	Based upon the presence of the CD, CE and CF payment modifiers, identify the AMCC tests ordered that are included and not included in the composite rate payment	Shared system
1.3	Based upon the determination of requirement 1.2, if 50 percent or more of the covered tests are included under the composite rate, no separate payment is made.	Shared system
1.4	Based upon the determination of requirement 1.2, if less than 50 percent are covered tests included under the composite rate, all AMCC tests for that date of service are payable.	Shared system
1.5	Reject line items that contain a procedure (identified in exhibit 1 and 2) with a modifier CE and a modifier 91 and no line item on the claim with modifier CE and no modifier 91.	Shared system
1.6	Reject line items that contain a procedure (identified in exhibits 1 and 2) with a modifier CF and a modifier 91 and no line item on the claim with modifier CF and no modifier 91.	Shared system
1.7	FI must return any claims for additional tests for any date of service within the billing period when the provider has already submitted a claim. Instruct the provider to adjust the first claim.	FI or Shared system
1.8	Do not apply the 50/50 rule to line items for one of the chemistries in exhibits 1 or 2 that contain modifiers CE or CF and modifier 91 on the line item.	Shared system

Carrier Business Requirements for ESRD Reimbursement of AMCC Tests:

Requirement #	*Requirements*	*Responsibility*
1	*The standard systems shall calculate payment at the lowest rate for these automated tests even if reported on separate claims for services performed by the same provider, for the same beneficiary, for the same date of service*	*Standard Systems*
2	*Standard Systems shall identify the AMCC tests ordered that are included and are not included in the composite rate payment based upon the presence of the "CD," "CE" and "CF" modifiers.*	*Standard Systems*
3	*Based upon the determination of requirement 2 if 50 percent or more of the covered services are included under the composite rate payment, Standard Systems shall indicate that no separate payment is provided for the services submitted for that date of service.*	*Standard Systems*
4	*Based upon the determination of requirement 2 if less than 50 percent are covered services include under the composite rate, Standard Systems shall indicate that all AMCC tests for that date of service are payable under the 50/50 rule.*	*Standard Systems*
5	*Standard Systems/local carriers shall return as unprocessable line items that contain a procedure reported with modifier "CE" and modifier 91 and no line item on the claim or a claim in history or in cycle for that date of service with modifier "CE" only.*	*Standard Systems/Carriers*
6	*Standard Systems/local carriers shall return as unprocessable line items that contain a procedure reported with modifier "CF" and modifier 91 and no line item on the claim or a claim in history or in cycle for that date of service with modifier "CF" only.*	*Carriers*

7	*Standard Systems shall not apply the 50/50 rule to line items for one of the chemistries that contain modifiers "CE" or "CF" and modifier 91 on the line item.*	*Standard Systems*
8	*Standard Systems shall adjust the previous claim when the incoming claim is compared to the claim on history and the action is to deny the previous claim. Spread the payment amount over each line item on both claims (the adjusted claim and the incoming claim).*	*Standard Systems*
9	*Standard Systems shall spread the adjustment across the incoming claim unless the adjusted amount would exceed the submitted amount of the services on the claim.*	*Standard System*
10	*Local carriers shall return as unprocessable claims submitted as outlined in business rules 5 and 6. When returning as unprocessable line items based upon the requirements of 5 and 6, local carriers shall use remittance advice remark code M78, reason code 125.*	*Carriers*
11	*Local carriers shall return an unprocessable lab panel codes billed with the "CD", "CE", and "CF" modifiers. When returning an unprocessable these lab panel codes use remittance advice remark code N56, reason code 4.*	*Carriers*
12	*Local carriers shall return as unprocessable line items submitted with a "CD" modifier and "91" modifier on the same line item. When returning an unprocessable line items that contain a "CD" modifier and a " 91" modifier, local carriers shall use remittance advice remark code M78, reason code 125.*	*Carriers*

Examples of the Application of the 50/50 Rule

The following examples are to illustrate how claims should be paid. The percentages in the action section represent the number of composite rate tests over the total tests. If this percentage is 50 percent or greater, no payment should be made for the claim.

Example 1:

Provider Name: Jones Hospital

DOS 2/1/02

Claim/Services *82040 Mod CD*

82310 Mod CD

82374 Mod CD

82435 Mod CD

82947 Mod CF

84295 Mod CF

82040 Mod CD (Returned as duplicate)

84075 Mod CE

82310 Mod CE

84155 Mod CE

ACTION: 9 services total, 2 non-composite rate tests, 3 composite rate tests beyond the frequency, 4 composite rate tests; 4/9 = 44.4%<50% pay at ATP 09

Example 2:

Provider Name: Bon Secours Renal Facility

DOS 2/15/02

Claim/Services *82040 Mod CE and Mod 91*

84450 Mod CE

82310 Mod CE

82247 Mod CF

82465 No modifier present

82565 Mod CE

84550 Mod CF

82040 Mod CD

84075 Mod CE

82435 Mod CE

82550 Mod CF

82947 Mod CF

82977 Mod CF

ACTION: 11 services total, 6 non-composite rate tests, 4 composite rate tests beyond the frequency, 1 composite rate test; 1/11 = .09.4%<50% pay at ATP 12

Example 3:

Provider Name: Sinai Hospital Renal Facility

DOS 4/02/02

Claim/Services *82565 Mod CD*

83615 Mod CD

82247 Mod CF

82248 Mod CF

82040 Mod CD

84450 Mod CD

82565 Mod CE

84550 Mod CF

82248 Mod CF (Duplicate

ACTION: 8 services total, 4 composite rate tests; 4/8 = 50%, therefore no payment is made

Example 4:

Provider Name: Dr. Andrew Ross

DOS 6/01/02

Claim/Services *84460 Mod CF*

82247 Mod CF

82248 Mod CF

82040 Mod CD

84075 Mod CD

84450 Mod CD

ACTION: 6 services total, 3 non-composite rate tests and 3 composite rate tests; 3/6 = 50%, therefore no payment.

Example 5: (Carrier Processing Example Only)

Payment for first claim, second creates a no payment for either claim

Provider Name: Dr. Andrew Ross

DOS 6/01/02

84460 Mod CF

82247 Mod CF

82248 Mod CF

ACTION: 3 services total, 3 non-composite rate tests, 0 composite rate tests beyond the frequency, and 0 composite rate tests tests, 0/3 = 0%, thereforeATP 03

Second Claim: No payment.

Provider Name: Dr. Andrew Ross

DOS 6/01/02

82040 Mod CD

84075 Mod CD

84450 Mod CD

ACTION: An additional 3 services are billed, 0 non-composite rate tests, 8 composite rate test beyond the frequency, 3 composite rate tests. For both claims there are 6 services total, 3 non-composite rate tests and 3 composite rate tests; 3/6 = 50% $\geq$ 50%, therefore no payment. An overpayment should be recovered for the ATP 03 payment