CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 198 **Date: JUNE 4, 2004**

CHANGE REQUEST 2813

NOTE: Transmittal 164 dated April 30, 2004, is being rescinded and replaced with transmittal, dated June 4, 2004. The only changes on this transmittal are the effective and implementation date. All other information remains the same.

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. CR 2813 was initially communicated on February 6, 2004. There is no change in the instruction. The only reason this CR is being re-communicated is because it is implemented over multiple releases. These files are the identical files contained in Pub 100-04, Transmittal 79. The only file not being re-communicated is the manual instruction; refer to Pub 100-04, Transmittal 79 for the manual instruction.

NEW/REVISED MATERIAL - EFFECTIVE DATE: October 4, 2004
***IMPLEMENTATION DATE: January 3, 2005**

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**
	Manual Instruction
	Confidential Requirements
	One-Time Notification

Attachment - Business Requirements

Pub. 100-04	Transmittal: 198	Date: June 4, 2004	Change Request 2813

NOTE: The business requirements for Transmittal 164 dated April 30, 2004, was replaced with the business requirements for Transmittal, dated June 4, 2004. The only changes on these business requirements are the effective and implementation date. All other information remains the same.

SUBJECT: End Stage Renal Disease (ESRD) Reimbursement for Automated Multi-Channel Chemistry Test(s)

I. GENERAL INFORMATION

A. Background:

CR 2813 was initially communicated on February 6, 2004. There is no change in the instruction. The only reason this CR is being re-communicated is because it is implemented over multiple releases. These files are the identical files contained in Pub 100-04, Transmittal 79. The only file not being re-communicated is the manual instruction; refer to Pub 100-04, Transmittal 79 for the manual instruction.

Medicare's composite rate payment to an ESRD facility or monthly capitation payment (MCP) to a physician includes reimbursement for certain routine clinical laboratory test furnished to an ESRD beneficiary. However, separate payment for such clinical laboratory test may be made when more than 50 percent of all Medicare-covered laboratory services furnished on a particular date of service are Automated Multi-channel Chemistry (AMCC) test that are not included in the composite payment rate. When the 50 percent threshold is met (for a particular date of service), then all laboratory tests (composite payment rate and non-composite payment rate tests) furnished on that date are separately payable. Conversely, if the 50 percent threshold is not met (for a particular date of service) then no laboratory tests (including non-composite payment rate tests) furnished on that date of service are separately payable.

The laboratory tests subject to the rule are those tests that are included within AMCC tests and then only when furnished to an ESRD beneficiary based upon an order by a doctor rendering care in the dialysis facility or MCP physician for the diagnosis and treatment of the beneficiary's ESRD.

The Office of Inspector General (OIG) conducted several audits and concluded that Medicare payments for ESRD laboratory related test are not in compliance with our payment policy. In response to the payment vulnerabilities identified by the OIG, these business requirements direct changes to the Carrier standard systems to ensure that ESRD laboratory claims are processed and paid in accordance with our payment policy.

B. Policy: An allowance for AMCC tests for an ESRD beneficiary is included under the composite payment rate to the ESRD facility or capitation payment to the MCP physician.

Separate payment for such tests is not made except as permitted under the payment rule specified below. The policy permits separate payment for AMCC tests for an ESRD beneficiary when more than 50 percent of all Medicare-covered AMCC tests furnished on a particular date of service are tests that are not included in the composite payment rate paid to the ESRD facility or capitation payment made to the MCP physician. In that event, all of the AMCC tests (composite payment rate tests and non-composite payment rate tests) furnished on that date are separately payable. Conversely, if the threshold is not met (for a particular date of service), then no AMCC test (including non-composite payment rate tests) furnished on that date are separately payable.
With respect to the application of the payment policy for AMCC tests for ESRD beneficiaries, the following apply:

1) Payment is at the lowest rate even if those automated tests were submitted as separate claims for test performed by the same provider, for the same beneficiary, for the same date of service.

2) Identify for a particular date of service, the AMCC tests ordered that are included in the composite rate and those that are not included. The composite payment rate is defined for Hemodialysis, Continuous Cycling Peritoneal Dialysis (CCPD), and Hemofiltration (Attachment 1) and for Continuous Ambulatory Peritoneal Dialysis (CAPD) (Attachment 2).

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

4) If more than 50 percent of the covered tests are non-composite payment rate tests, all AMCC tests submitted for that date of service are separately payable.

5) A non-composite payment rate test is defined as any test separately reimbursable outside of the composite payment rate or beyond the normal frequency covered under the composite payment rate that is reasonable and necessary.

6) All chemistries ordered for beneficiaries with chronic dialysis for ESRD must be billed individually and must be rejected when billed as a panel.

Three pricing modifiers discreetly identify the different payment situations for ESRD AMCC services. The physician that orders the tests is responsible for identifying the appropriate modifier when ordering the test as follows:

- 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

- CE – AMCC tests 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

- CF – AMCC tests has been ordered by an ESRD facility or MCP physician that is not part of the composite rate and is separately billable

The ESRD clinical laboratory test identified with modifiers "CD", "CE" or "CF" may not be billed as organ or disease panels. Upon the effective date of this business requirement, all ESRD clinical laboratory test must be billed individually.

The carrier standard system must calculate the number of AMCC services provided for any given date of service. For a date of service, sum all AMCC tests with a CD modifier and divide by the sum of all line items with a CD, CE or CF modifier for the same beneficiary and billing supplier/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 test.

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

Adjust the previous claim when the incoming claim for a date of service is compared to a claim on history and the action is to pay a previously denied claim. Spread the payment amount over each line item on both claims (the claim on history and the incoming claim).

Adjust the previous claim when the incoming claim for a date of service is compared to a claim on history and the action is deny a previously paid claim.

Implementation of this policy:

ESRD facilities when ordering an ESRD-related AMCC tests must specify for each 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 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 CMS is staggering the programming for this payment policy over multiple releases. Independent labs are not to revise their billing procedures at this time. The CMS will release additional provider education in the future to educate providers regarding the effective date of revised billing procedures. Carriers shall install front-end edits to reject any line items containing the "CD", "CE" or "CF" modifiers until further notice.

C. Provider Education: Carriers shall not post any information from this business requirement on their Web site or regularly scheduled bulletins. CMS is staging the standard system changes over multiple releases. Therefore, carriers will be notified in a subsequent business requirement regarding the effective date of the revised billing procedures for independent labs and their billing of AMCC tests for ESRD beneficiaries, along with any provider education/notification requirements.

II. BUSINESS REQUIREMENTS

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

Requirement #	Requirements	Responsibility
2813.1	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
2813.2	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
2813.3	Based upon the determination of requirement 2 if 50 percent or more of the covered services are included under the composite rate, Standard Systems shall indicate that no separate payment is provided for the test submitted for that date of service.	Standard Systems
2813.4	Based upon the determination of requirement 2	Standard Systems

	if less than 50 percent are covered services included under the composite rate, Standard Systems shall indicate that all AMCC tests for that date of service are payable under the 50/50 rule.	
2813.5	Local Carriers shall return as unprocessable line items that contain a procedure (identified in attachments 1 and 2) 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
2813.6	Local Carriers shall return as unprocessable line items that contain a procedure (identified in attachments 1 and 2) 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
2813.7	Standard Systems shall not apply the 50/50 rule to line items for one of the chemistries in attachments 1 or 2 that contain modifiers "CE" or "CF" and modifier 91 on the line item.	Standard Systems
2813.8	Standard Systems shall adjust the previous claim when the incoming claim is compared to the claim on history and the action is to adjust payment for a previously denied claim. Spread the payment amount over each line item on both claims (the adjusted claim and the incoming claim).	Standard Systems
2813.9	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
2813.10	Local Carriers shall return as unprocessable claims submitted as outlined in business rules 5 and 6. When returning as unprocessable the line items based upon the requirements of 5 and 6 local carriers shall use remittance advice remark code M78, reason code 125.	Carriers
2813.11	Local Carriers shall return an unprocessable lab panel codes billed with the "CD", "CE", and "CF" modifiers. When rejecting these lab panel codes billed used remittance remark advice remark code N56, reason code 4.	Carriers
2813.12	Local Carriers shall return as unprocessable line items submitted with a CD modifier and a 91 modifier on the same line item. When returning as unprocessable lines that contain a CD	Carriers

	modifier and a 91 modifier on the same line item, local carriers shall use remittance advice remark code M78, reason code 125.	

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: Partial Implementation October 4, 2004 **Implementation Date: January 3, 2005** **Pre-Implementation Contact(s): Joan Proctor-Young (410) 786-0949** **Post-Implementation Contact(s): regional offices**	**These instructions shall be implemented within your current operating budget.**

3 Attachments

Attachment 3

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/Svcs. 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% payable at the ATP 09 rate.

Example 2:
Provider Name: Bon Secours Renal Facility
DOS 2/15/02
Claim/Svcs. 82040 Mod CE and Mod 91
84450 Mod CE
82310 Mod CE
82247 Mod CF
82465 No modifier present
82565 Mod CF
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% < 50%, payable at the ATP 12 rate.

Example 3:
Provider Name: Sinai Hospital Renal Facility
DOS 4/02/02
Claim/Svcs. 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 total services, 4 composite 4/8 = 50%, therefore no payment is made

Example 4:
Provider Name: Dr. Andrew Ross
DOS 6/01/02 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:
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, 0/3 = 0%, therefore payable at the ATP 03 rate.
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, 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.