Medlearn Matters
Information for Medicare Providers

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Note: This article was re-issued on August 17 to conform with the re-issued CR2813 on June 4. The effective and implementation dates and the transmittal number are the only changes resulting from this re-issuance.

End Stage Renal Disease (ESRD) Reimbursement for Automated Multi-Channel Chemistry Tests (AMCC)

Provider Types Affected

Physicians, suppliers, and ESRD facilities.

Provider Action Needed

Affected providers should note that this instruction begins the implementation of procedures to enforce compliance with the 50/50 payment policy for End Stage Renal Disease (ESRD)-related laboratory services. The Centers for Medicare & Medicaid Services (CMS) is staggering the programming for this payment policy over multiple releases. Independent labs are not to revise their billing procedures at this time. CMS will release additional provider education in the future to educate providers regarding the effective date of revised billing procedures. Medicare carriers will have front-end edits to reject any line items containing the "CD," "CE," or "CF" modifiers, as referenced in this article, until further notice.

Background

Medicare's composite rate payment to an ESRD facility or Monthly Capitation Payment (MCP) to a physician includes reimbursement for certain routine clinical laboratory tests furnished to an ESRD beneficiary.

- Separate payment for AMCC tests (for an ESRD beneficiary) **is** permitted 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 this event, all of the AMCC tests (composite payment rate tests and non-composite payment rate tests) furnished on that date are separately payable.
- Separate payment for AMCC tests (for an ESRD beneficiary) **is not** permitted if **less** 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 this event, no AMCC test (including non-composite payment rate tests) furnished on that date are separately payable.

In other words, if 50 percent or more of the covered tests are included under composite payment rate tests, 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. However, if more than 50 percent of the covered tests are non-composite payment rate tests, then all AMCC tests submitted for that date of service are separately payable.

Defining Non-Composite Payment Rate Tests

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. Also, all chemistries ordered for beneficiaries with chronic dialysis for ESRD must be billed individually and must be rejected when billed as a panel.

The physician who orders the tests is responsible for identifying the appropriate modifier when ordering the test(s), and three pricing modifiers discreetly identify the different payment situations for ESRD AMCC services as follows:

- CD – AMCC test that has been ordered by an ESRD facility or MCP physician that is part of the composite rate and is not separately billable.
- CE – AMCC test that 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 that is not part of the composite rate and is a separately billable test that has been ordered by an ESRD facility or MCP physician.

In addition, 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 requirement, all ESRD clinical laboratory tests must be billed individually.

Carrier Standard System Calculation

The Medicare carrier’s standard system will calculate the number of AMCC services provided for any given date of service. For a date of service, it should add all AMCC tests that have 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, the carrier will not pay for the test.
- If the result of the calculation for a date of service is less than 50 percent, the carrier will pay for all of the test.

The carrier will adjust a 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. The Medicare carrier will spread the payment amount over each line item on both claims (the claim on history and the incoming claim).

ESRD Facilities

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

- Part of the composite rate and not separately payable;
- 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
- Not part of the ESRD composite rate and thus separately payable.

Laboratories

Laboratories must identify the following:

- Tests not included within the ESRD facility composite rate payment.
- Tests ordered for chronic dialysis for ESRD as follows:
  - Modifier CD: AMCC Test that is part of the composite rate and is not separately billable and has been ordered by an ESRD facility or MCP physician.
  - Modifier CE: AMCC Test that is a composite rate test but is beyond the normal frequency covered under the rate and is separately reimbursable based on medical necessity and has been ordered by an ESRD facility or MCP physician.
  - Modifier CF: AMCC Test that is not part of the composite rate and is separately billable and has been ordered by an ESRD facility or MCP physician.
- Bill all tests ordered for a chronic dialysis ESRD beneficiary individually and not as a panel.

The laboratory tests subject to this rule are those tests 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
- An MCP physician for the diagnosis and treatment of the beneficiary's ESRD.

Implementation

The implementation date is January 3, 2005. The partial implementation on October 4, 2004, includes the calculation of payments at the lowest rate for these automated tests, application of the 50/50 rule, comparing claims to prior claims in history for the same date of service, and the rejection of any line items with the "CD," "CE," and "CF" modifiers.

Related Instructions

The *Medicare Claims Processing Manual, Chapter 16 (Laboratory Services from Independent Labs, Physicians, and Providers), Section 40 (Billing for Clinical Laboratory Tests), Subsection 6.1 (Billing for End Stage Renal Disease (ESRD) Related Laboratory Tests)* was revised and can be found in Transmittal 79 of Pub 100-04, the original release of CR2813. This original CR may be found at:

http://www.cms.hhs.gov/manuals/pm_trans/R79CP.pdf

The official instruction issued to your carrier on these changes may be found at:

http://www.cms.hhs.gov/manuals/pm_trans/R198CP.pdf

This transmittal, which is Transmittal 198, also has some helpful examples of billing these tests as well as tables to show which tests are part of the composite rate and which are not.

If you have any questions regarding these changes, please contact your carrier at their toll-free number which may be found at:

http://www.cms.hhs.gov/medlearn/tollnums.asp