Program Memorandum Intermediaries

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

Transmittal A-03-033 **Date: MAY 2, 2003**

CHANGE REQUEST 2277

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

I. GENERAL INFORMATION

A. Scope:

The purpose of this program memorandum is to implement claims processing procedures to ensure that automated multi-channel chemistry tests are paid in accordance with Provider Reimbursement Manual (PRM) §2711.

B. Background :

The Office of Inspector General (OIG) conducted several studies which identified that Medicare payments for ESRD laboratory related services are not paid in compliance with our payment policy. In response to the payment vulnerabilities identified by the OIG, the claims processing instructions contained in this PM direct all intermediaries to implement changes to ensure that ESRD laboratory claims that are identified by the provider are paid in accordance with our payment policy.

Medicare provides reimbursement for certain routine clinical diagnostic laboratory tests rendered to a ESRD beneficiary within the composite rate payment to the ESRD facility. PRM §2711 states that separate payment may be made for the clinical diagnostic laboratory test rendered on a particular date of service when 50 percent or more of the covered tests billed for that particular date of service are non-composite rate tests.

C. Policy:

Clinical diagnostic laboratory tests included under the composite rate payment are paid through the composite rate paid by the intermediary. To determine if separate payment is allowed for non-composite rate tests for a particular date of service, 50 percent or more of the covered tests must be non-composite rate tests.

Medicare will apply the following to AMCC tests for ESRD beneficiaries:

1) Payment is at the lowest rate for services 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 rate tests are defined for Hemodialysis, Intermittent Peritoneal Dialysis (IPD), 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 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.
4) If less than 50 percent of the covered tests are composite rate tests, all AMCC tests submitted for that Date of Service (DOS) are separately payable.

5) A non-composite 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.

D. Implementation:

Three pricing modifiers discretely identify the different payment situations for ESRD AMCC tests. The physician that orders the tests is responsible for identifying the appropriate modifier when ordering the tests.

- 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 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
- 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

ESRD clinical diagnostic laboratory tests identified with modifiers "CD", "CE" or "CF" may not be billed as organ or disease panels. Effective October 1, 2003, all ESRD clinical diagnostic laboratory tests must be billed individually.

The intermediary standard 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 by the sum of all tests with a CD, CE and CF modifier for the same beneficiary and billing 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 tests.

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

All tests for a date of service must be billed on the monthly ESRD bill. Providers must send in an adjustment if they identify additional tests that have not been billed.

Provider Education

In your next regularly scheduled bulletin and within 30 days of release of this pm, you must publish this information on your website.

II. BUSINESS REQUIREMENTS

Requirement #	Requirements	Responsibility
1.1	The Intermediary standard system must RTP a claim for AMCC tests when a claim for that date of service has already been submitted.	Standard 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	Standard 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.	Standard 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.	Standard System
1.5	Reject line items that contain a procedure (identified in attachment 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.	Standard System
1.6	Reject line items that contain a procedure (identified in attachment 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.	Standard System
1.7	Intermediary must return any claims for additional tests for any date of service within the billing period when a claim has already been submitted by the provider. Instruct the provider to adjust the first claim.	Intermediary or Standard System
1.8	Do 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 System

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces:

D. Contractor Financial Reporting /Workload Impact:

E. Dependencies:

F. Testing Considerations:

IV. ATTACHMENTS

Implementation Date: October 1, 2003 **Discard Date**: October 1, 2004 **Post-Implementation Contact**: Regional Office **Effective Date:** October 1, 2003	**Funding:** These instructions should be implemented within your current operating budget. **Pre-Implementation Contact:** Linda Easter - 410-786-6978 Doris Barham - 410-786-6146 Joan Proctor-Young – 410-786-0949

IV.

Attachment 1

	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			
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	X		
20	Triglycerides	84478			
21	Urea nitrogen (BUN)	84520	X		
22	Uric Acid	84550			

= non-composite rate test

= composite rate test

Attachment 2

	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

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 1
82310 Mod 1
82374 Mod 1
82435 Mod 1
82947 Mod 3
84295 Mod 3
82040 Mod 1 (Returned as duplicate)
84075 Mod 2
82310 Mod 2
84155 Mod 2

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/Svcs. 82040 Mod 2 and Mod 91
84450 Mod 2
82310 Mod 2
82247 Mod 3
82465 No modifier present
82565 Mod 3
84550 Mod 3
82040 Mod 1
84075 Mod 2
82435 Mod 2
82550 Mod 3
82947 Mod 3
82977 Mod 3

ACTION: 11 services total, 6 non-composite rate tests, 4 composite rate tests beyond the frequency, 1 composite rate test; 1/11 = .09% < 50%, pay at ATP 11.

Example 3:
Provider Name: Sinai Hospital Renal Facility
Bene 1: DOS 4/02/02
Claim/Svcs. 82565 Mod 1
83615 Mod 1
82247 Mod 3
82248 Mod 3
82040 Mod 1
84450 Mod 1
82565 Mod 2
84550 Mod 3
82248 Mod 3 (Duplicate)

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

Example 4:
Provider Name: Dr. Andrew Ross
Bene 1: DOS 6/01/02

84460 Mod 3
82247 Mod 3
82248 Mod 3
82040 Mod 1
84075 Mod 1
84450 Mod 1

ACTION: 6 services total, 3 non-composite rate tests and 3 composite rate tests; 3/6 = 50%, therefore no payment. An overpayment should be recovered for the ATP 03 payment amount.