CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1769	**Date: July 10, 2009**
	Change Request 6515

This transmittal rescinds and replaces transmittal 1763, dated July 2, 2009 to change the effective and implementation date of July 2, 2009 to July 31, 2009. All other information remains the same.

Subject: ESRD: Placement of a List of Diagnostic Tests that are Considered End Stage Renal Disease (ESRD

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to place a listing of diagnostic tests that are considered ESRD-related as Exhibit 1(New) at the end of Publication 100-04, Chapter 16. This listing was inadvertently omitted from the manual during the implementation of CR 2906, Transmittal 69, issued January 23, 2004.

Existing Exhibit 1 and 2 in Section 120.1 are being deleted as duplicate charts are currently located in Publication 100-02, Chapter 11, §30.2.2.

Section 40.6.2.3 has also been re-titled.

New / Revised Material
Effective Date: July 31, 2009
Implementation Date: July 31, 2009

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	16/Table of Contents
R	16/40.6/Billing for ESRD Related Laboratory Tests
R	16/40.6.1/Automated Multi-Channel Chemistry (AMCC) Tests for ESRD beneficiaries - FIs
R	16/40.6.2.3/Skilled Nursing Facility (SNF) Consolidated Billing (CB) Editing and Separately Billed ESRD Laboratory Test Furnished to Patients of Renal Dialysis Facilities
R	16/120.1/Negotiated Rulemaking Implementations

N	16/Exhibit 1/List of Diagnostic Tests that are Considered End Stage Renal Disease (ESRD)

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1769	Date: July 10, 2009	Change Request: 6515

This transmittal rescinds and replaces transmittal 1763, dated July 2, 2009 to change the effective and implementation date of July 2, 2009 to July 31, 2009. All other information remains the same.

SUBJECT: ESRD: Placement of a List of Diagnostic Tests that are Considered End Stage Renal Disease (ESRD)

Effective Date: July 31, 2009

Implementation Date: July 31, 2009

I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to place a listing of diagnostic tests that are considered ESRD-related as Exhibit 1 (formerly Attachment 1 in CR 2906) at the end of Publication 100-04, Chapter 16. This listing was inadvertently omitted from the manual during the implementation of CR 2906, Transmittal 69, issued January 23, 2004. This CR also deletes the existing Exhibits 1 and 2. These exhibits duplicate charts currently located in Publication 100-02, Chapter 11, §30.2.2.

The purpose of CR 2906 was to address specific areas of concerns regarding the revisions to Common Working File edits for Skilled Nursing Facilities (SNF) consolidated billing to permit payment for certain diagnostic services furnished to beneficiaries receiving treatment for ESRD at an Independent Provider-based dialysis facility. One of the areas of concern was that providers/suppliers needed a listing of diagnostic tests that are considered ESRD-related that would require the "CB" modifier. Consequently, a list defining specific diagnostic tests as ESRD-related was included in CR 2906. This list applies only to SNF consolidated billing.

According to CR 2906, any diagnostic services related to the beneficiary's ESRD treatment/care must be submitted using the "CB" modifier, however, if these services are not listed in Exhibit 1 (Labeled as Attachment 1 in CR 2906), the carrier may require supporting medical documentation.

B. Policy: Contractors are to make notation that a list of diagnostic tests that are considered ESRD-related is available as Exhibit 1 in the Medicare Claims Processing Manual as Publication 100-04, Chapter 16 at the end of the chapter.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6515.1	Contractors shall refer to Exhibit 1 for a list of diagnostic	X		X	X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	tests that must be submitted with the "CB" modifier.										

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6515.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X	X						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
6515.1	CR 2906 and CR 2475

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Wendy Knarr at Wendy.Knarr@ccms.hhs.gov or dial #711 for relay service and have the relay agent dial l410-786-0843.

Post-Implementation Contact(s): Your appropriate RO

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs),* include the following statement:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Table of Contents

(Rev.1769, 07-10-09)

40.6 - Billing for End Stage Renal Disease (ESRD) Related Laboratory Tests

(Rev.1769, Issued: 07-10-09, Effective/Implementation: 07-31-09)

PM AB-98-7, PRM 1 2711, B3-4270.2

Hemodialysis, Intermittent Peritoneal Dialysis (IPD), and Continuous Cycling Peritoneal Dialysis (CCPD) Tests

With some exceptions, laboratory tests for hemodialysis, intermittent peritoneal dialysis (IPD), and continuous cycling peritoneal dialysis (CCPD) are included in the ESRD composite rate.

For a particular date of service to a beneficiary, if 50 percent or more of the covered laboratory tests are noncomposite rate tests Medicare allows separate payment beyond that included in the composite rate.

For a description of what laboratory tests and other tests are included in the composite rate and under what conditions such tests may qualify for additional payment in addition to the composite rate, see *the Medicare Benefit Policy Manual, Publication 100-02, Chapter 11, Section 30.2 and Chapter 8, Section 50.1 of this manual.*

Clinical diagnostic laboratory tests included under the composite rate payment are paid through the composite rate paid by the FI.

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

(Rev.1769, Issued: 07-10-09, Effective/Implementation: 07-31-09)

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 tests performed by the same provider, for the same beneficiary, for the same date of service.

- The facility/laboratory 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 *Publication 100-02, Chapter 11, Section 30.2.2 for the chart detailing the composite rate tests for Hemodialysis, Intermittent Peritoneal Dialysis (IPD), Continuous Cycling Peritoneal Dialysis (CCPD), and*

Hemofiltration as well as a second chart detailing the composite rate tests for 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

Requirement Number	Requirements	Responsibility
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	Effective for claims with dates of service on or after January 1, 2006, include any line items with a modifier 91 used in conjunction with the "CD," "CE," or "CF" modifier in the calculation of the 50/50 rule.	Shared System
1.6	FIs 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
1.7	After the calculation of the 50/50 rule, services used to determine the payment amount may never exceed 22. Effective for claims with dates of service on or after January 1, 2006, accept all valid line items submitted for the date of service and pay a maximum of the ATP 22 rate.	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	Standard Systems

	presence of the “CD,” “CE” and “CF” modifiers.	
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 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.	Standard Systems
5	Effective for claims with dates of service on or after January 1, 2006, include any line items with a modifier 91 used in conjunction with the “CD,” “CE,” or “CF” modifier in the calculation of the 50/50 rule.	Standard Systems
6	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
7	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
8	After the calculation of the 50/50 rule, services used to determine the payment amount may never exceed 22. Accept all valid line items for the date of service and pay a maximum of the ATP 22 rate.	Standard Systems

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: 12 services total, 5 non-composite rate tests, 6 composite rate tests beyond the frequency, 1 composite rate test; 1/12 = 8.3%<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, 3 non-composite rate tests, 4 composite rate tests, 1 composite rate test beyond the frequency; 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 6/01/06 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 ATP 03

Second Claim: No payment.

Provider Name: Dr. Andrew Ross

DOS 6/01/06 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.

40.6.2.3 – *Skilled Nursing Facility (SNF) Consolidated Billing (CB) Editing and Separately Billed ESRD Laboratory Test Furnished to Patients of Renal Dialysis Facilities*

(Rev.1769, Issued: 07-10-09, Effective/Implementation: 07-31-09)

Effective April 1, 2003, for DOS on or after April 1, 2001, CWF will not apply the SNF CB edits to line items that contain the CB modifier. A provider or supplier may use the "CB" modifier only when it has determined that: (a) the beneficiary has ESRD

entitlement, (b) the test is related to the dialysis treatment for ESRD, (c) the test is ordered by a doctor providing care to patients in the dialysis facility, and (d) the test is not included in the dialysis facility's composite rate payment.

Those diagnostic tests that are presumptively considered to be dialysis-related and, therefore, appropriate for submission with the " CB" modifier are identified in *Exhibit 1*. This list was not designed as an all- inclusive list of Medicare covered diagnostic services. Additional diagnostic services related to the beneficiary's ESRD treatment/care may be considered dialysis-related. However, if these services are not included in our listing, the contractor may require supporting medical documentation.

When a hospital laboratory is billing for laboratory services ordered by an ESRD facility and the patient (beneficiary) is a SNF resident under a Part A stay, the hospital laboratory must use the "CB" modifier for those services excluded from consolidated billing.

Beneficiaries in a SNF Part A stay are eligible for a broad range of diagnostic services as part of the SNF Part A benefit. Physicians ordering medically necessary diagnostic test that are not directly related to the beneficiary's ESRD are subject to the SNF consolidated billing requirements. Physicians may bill the contractor for the professional component of these diagnostic tests. In most cases, however, the technical component of diagnostic tests is included in the SNF PPS rate and is not separately billable to the contractor. Physicians should coordinate with the SNF in ordering such tests since the SNF will be responsible for bearing the cost of the technical component.

120.1 - Negotiated Rulemaking Implementation

(Rev.1769, Issued: 07-10-09, Effective/Implementation: 07-31-09)

The following requirements apply to service providers:

- The date of service should be reported as the date of specimen collection.
- The person obtaining the specimen must furnish the date of collection for the specimen to the entity billing Medicare.
- For specimen collections that span more than a 24-hour period, the date of service should be reported as the date the collection began.
- For laboratory tests that require a specimen from stored collections, the date of service should be defined as the date the specimen was obtained from the archives.
- If a situation occurs that does not correspond to the two situations described, the contractor will submit the question to the RO with the appropriate documentation. The RO will contact the Division of Supplier Claims Processing in CMS, which will serve as the point of contact.

Matching of Diagnosis to Procedure

During claims processing and adjudication, the contractor adheres to the following:

- If there is a LMRP or NCD for one or more of the services included on the claim, the contractor reviews all of the diagnosis codes in making a determination regarding medical necessity of the service.
- Even though a claim matches diagnosis to procedure in accordance with an NCD, other rules of adjudication may apply, which could result in denial.
- Diagnoses are required on all claims.

Physicians Reporting Diagnosis Codes When A Diagnostic Test Is Ordered

Section 4317 of the Balanced Budget Act of 1997 provides, with respect to diagnostic laboratory and certain other services, that “if the Secretary (or fiscal agent of the Secretary) requires the entity furnishing the services to provide diagnostic or other medical information to the entity, the physician or practitioner ordering the service shall provide that information to the entity at the time the service is ordered by the physician or practitioner.” A laboratory or other provider must report on a claim for Medicare payment the diagnostic code(s) furnished by the ordering physician. In the absence of such coding information, the laboratory or other provider may determine the appropriate diagnostic code based on the ordering physician’s narrative diagnostic statement or seek

diagnostic information from the ordering physician/practitioner. However, a laboratory or other provider may not report on a claim for Medicare payment a diagnosis code in the absence of physician-supplied diagnostic information supporting such code.

Clarification of the Use of the Term "Screening" or "Screen"

The final rule clarifies that effective February 21, 2002, the use of the term "screening" or "screen" in CPT code descriptor does not necessarily describe a test performed in the absence of signs and symptoms of illness, disease or condition. Contractors do not deny a service based solely on the presence of the term "screening" or "screen" in the descriptor.

Tests that are performed in the absence of signs, symptoms, complaints, personal history of disease, or injury are not covered except when there is a statutory provision that explicitly covers tests for screening as described.

If a person is tested to rule out or to confirm a suspected diagnosis because the patient has a sign and/or symptoms, this is considered a diagnostic test, not a screening test. Contractors have discretionary authority to make reasonable and necessary scope of benefit determinations.

Exhibit 1 – *List of Diagnostic Tests that are Considered End Stage Renal Disease (ESRD)*

(Rev.1769, Issued: 07-10-09, Effective/Implementation: 07-31-09)

Refer to section 40.6.2.3 for guidance on the usage of this list.

71010 Chest x-ray
71015 Chest x-ray
71020 Chest x-ray
71021 Chest x-ray
71022 Chest x-ray
71030 Chest x-ray
71035 Chest x-ray
73120 X-ray hand
75710 Artery x-rays, arm/leg
75716 Artery x-rays, arm/leg
75774 Artery x-rays, arms/legs
75790 Artery x-ray, each vessel
75820 Visualize A-V shunt
75822 Vein x-ray, arm/leg
75893 Vein x-ray, arms/legs
75894 Transcath therapy, embolization
75896 X-rays, transcath therapy
75898 X-rays, transcath therapy
75901 Mechanical removal of pericath obstructive material
75902 Mechanical removal of intraluminal obstructive material
75961 Transcath retrieval of intravascular foreign body
75962 Transcath balloon angioplasty
75964 Transcath balloon angioplasty, each additional
76070 Computed tomography, bone mineral density study, axial
76075 Dual energy DEXA, bone density study, axial
76080 Radiologic exam, abscess, fistual or sinus tract study
76092 Screening mammography bilateral
76778 Ultrasound, transplanted kidney
78070 Parathyroid nuclear imaging
78351 Bone density, dual photon absorptionmetry
80048 Basic metabolic panel
80051 Electrolyte panel
80053 Comprehensive Metabolic Panel
? 80061 Lipid panel
80069 Renal function panel
80074 Acute hepatitis panel
80076 Hepatic function panel
80197 Tacrolimus
80410 Calcitonin stim panel
81000 Urinalysis with microscopy
81001 Urinalysis, auto w/scope
81002 Urinalysis nonauto w/o scope
81003 Urinalysis, auto, w/o scope
81005 Urinalysis, qual or semi-quant
81007 Urine screen for bacteria, except by culture or dipstick
81015 Microscopic exam of urine
82009 Test for acetone/ketones,qual

82010 Acetone assay, quant
82017 Acylcarnitines, quant
82040 serum albumin
82042 albumin, urine quant or other source
82108 Assay of aluminum
82232 Beta2microglobulin (monitor large molecular weigh solute clearance by dial
82247 Bilirubin, total
82248 Bilirubin, direct
82306 Assay of vitamin D-3 (calcifediol)
82307 Assay of vitamin D (calciferol)
82308 Assay of calcitonin
82310 Assay of calcium
82330 Assay of calcium, ionized
82374 Bicarbonate (CO2)
82379 Assay of carnitine
82435 Chloride blood (needed to determine acid/base status)
82465 cholesterol, total serum
82550 CPK, total
82565 Assay of creatinine
82570 Assay of urine creatinine
82575 urine creatinine clearance test
82607 Vit B12
82728 ferritin
82746 serum folate
82747 RBC folate
82800 Blood Ggases, ppH onlyy
82803 Blood gases: pH, pO2 & pCO2
82805 Blood gases W/02 saturation
82810 Blood gases, O2 sat only
82945 Glucose other fluid
82947 Assay, glucose, blood quant
82948 Reagent strip/blood glucose
83540 Assay of iron
83550 Iron binding test
83735 magnesium (monitored to avoid hypermagnesium)
83937 Osteocalcin
83970 parathormone (PTH)
83986 Assay of body fluid acidity
84075 alkaline phosphatase
84100 Assay of phosphorus, inorganic
84105 urine phosphorus
84132 Assay of serum potassium
84133 urine potassium
84134 Assay of prealbumin
84155 Assay of protein
84160 serum protein by refractometry
84295 Assay of serum sodium
84315 Body fluid specific gravity
84450 Transferase (AST) (SGOT)
84460 Alanine amino (ALT) (SGPT)
84466 transferrin
84520 Urea nitrogen, quantitative
84540 Assay of urine/urea-n
84545 Urea-N clearance test
84630 zinc
85002 Bleeding time test

85004 Automated diff wbc count
85007 Bl smear w/diff wbc count
85008 Bl smear w/o diff wbc count
85009 Manual diff wbc count b-coat
85013 Spun microhematocrit
85014 Hematocrit
85018 Hemoglobin
85025 Complete CBC w/auto diff wbc
85027 Complete CBC, automated
85032 Manual cell count, each
85041 Automated RBC count
85044 Manual reticulocyte count
85045 Automated reticulocyte count
85046 Reticyte/hgb concentrate
85048 Automated leukocyte count
85049 Automated platelet count
85345 Coagulation time, Lee-White
85347 Coagulation time, activated
85348 Coagulation time, other methods
85520 Heparin assay
85610 Prothrombin time
85611 Prothrombin test,substitution
85651 sed rate
85652 automates sed rate
85730 thromboplastin time, partial (PTT)
85732 Thromboplastin time, partial, substitution
86590 Streptokinase, antibody
86644 CMV screen
86645 Cytomegalovirus antibody dfa (IgM)
86687 HTLV-I antibody
86688 HTLV-II antibody
86689 HTLV/HIV confirmatory test
86692 Hepatitis, delta agent
86701 HIV-1
86702 HIV-2
86703 HIV-1/HIV2, ,singgle assayy
86704 Hep B core antibody, total
86705 Hep b core antibody, IgM
86706 Hep B surface antibody
86707 Hep Be antibody
86709 Hep A, IgM antibody
86803 Hepatitis C ab test
86804 Hep C ab test, confirm
86812 HLA typing, A, B, or C
86813 HLA typing, A, B, or C, multiple antigens
86816 HLA typing, DR/DQ
86817 HLAy tpypigng, DR/DQ, multiple antigens
86900 Blood typing, ABO
86901 Rh typing
86903 Blood typing, antigen screen
86904 Blood typing, patient serum
86905 Blood typing, RBC antigens
86906 Blood typing, Rh phenotype
87040 culture, blood
87070 Culture, bacteria, other
87071 Culture bacteri aerobic other, quant

87073 Culture bacteria anaerobic, quant
87075 Culture bacteria anaerobic, any source w/ID
87076 Culture anaerobe ident, each
87077 Culture aerobic identify
87081 Culture screen only
87084 Culture w/ colony estimation
87086 Urine culture/quant colony count
87088 Urine bacteria culture, isolation & ID
87181 Microbe susceptible, diffuse
87184 Microbe susceptible, disk
87185 Microbe susceptible, enzyme
87186 Microbe susceptible, mic
87187 Microbe susceptible, mlc
87188 Microbe suscept, macrobroth
87190 Microbe suscept, mycobacteri
87197 Bactericidal level, serum
87205 Smear, gram stain
87271 CMV, DFA
87340 HepB surface antigen
87341 HepatitisB surface, ag, eia, neutralization
87350 HepatitisBe ag, eia
87380 Hepatitis delta ag, eia
87390 HIV-1 ag, eia
87391 HIV-2 ag, eia
87515 Hepatitis B, DNA, dir probe
87516 Hepatitis B, DNA, amp probe
87517 Hepatitis B, DNA, quant
87520 Hepatitis C, RNA, dir probe
87521 Hepatitis C, RNA, amp probe
87522 Hepatitis C, RN A, quant
87525 Hepatitis G, DNA, dir probe
87526 Hepatitis G, DNA, amp probe
87527 Hepatitis G, DNA, quant
89050 cell count, peritoneal fluid (no diff)
89051 cell count, peritoneal fluid with diff
93000 Echo exam of heart
93005 Electrocardiogram, tracing
93010 Electrocardiogram report
93040 Rhythm ECG with report
93041 Rhythm ECG, tracing
93042 Rhythm ECG with report
93307 Echo exam of heart
93308 Echo exam of heart, follow-up
93922 Extremity study
93923 Extremity study, multiple levels
93925 Lower extremity study - arterial
93926 Lower extremity study, limited- arterial
93930 Upper extremity study- arterial
93931 Upper extremity study, limited-arterial
93965 Extremity study-venous
93970 Extremity study-venous
93971 Extremity study, limited-venous
G0001 Routine venipuncture
G0202 Screening mammography, digital