CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 733

Department of Health & Human Services (DHHS)

Center for Medicare & Medicaid Services (CMS)

Date: OCTOBER 28, 2005

Change Request 4101

SUBJECT: Repeat Tests for Automated Multi-Channel Chemistries for End Stage Renal Disease beneficiaries

I. SUMMARY OF CHANGES: This change manualizes the End Stage Renal Disease (ESRD) procedure for both Carriers and Intermediaries and corrects a coding issue concerning repeat tests using the Current Procedure Terminology modifier 91.

NEW/REVISED MATERIAL
EFFECTIVE DATE: January 01, 2006
IMPLEMENTATION DATE: April 03, 2006

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	16/40/6/1/Automated Multi-Channel Chemistry (AMCC) Tests for ESRD Beneficiaries

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 733	Date: October 28, 2005	Change Request 4101

SUBJECT: Repeat Tests for Automated Multi-Channel Chemistries (AMCC) for End Stage Renal Disease Beneficiaries

I. GENERAL INFORMATION

A. **Background:** The Centers for Medicare & Medicaid Services (CMS) has issued prior instructions to the Medicare carriers regarding procedures to enforce compliance with the payment policy for End Stage Renal Disease (ESRD)-related Automated Multi-Channel Chemistry Tests (i.e., the ESRD 50/50 rule). The ESRD 50/50 rule requires a count of AMCC tests ordered to capture the number of tests included in the composite payment rate paid to the ESRD facility, or the monthly capitation payment made to the furnishing physician, versus the number of covered non-composite tests performed for the same beneficiary, on the same date of service. The proportion of composite versus non-composite tests calculated by the billing laboratory is used to determine whether separate payment may be made for all tests performed on that day.

In Change Request (CR) 2813, "End Stage Renal Disease (ESRD) Reimbursement for Automated Multi-Channel Chemistry Test(s)," the CMS directed Medicare carriers to make the necessary systems changes to implement front-end edits in preparation for the standard system implementation of this CR in the January 2005 release. (The carrier standard system changes needed to implement the new ESRD 50/50 rule compliance guidelines were partially implemented in the October 2004 release. Intermediary billing guidelines for ESRD 50/50 rule compliance have been in effect since October 2003.) CR 2813 also directed the carriers not to post any information concerning the business requirements associated with the implementation of this instruction until receiving further guidance from the CMS.

In October 2004, the CMS issued a companion instruction, CR 3501, authorizing the carriers to post the provider education article related to CR 2813 on the CMS Medlearn Matters Web site, and to supplement this article with any localized information that would benefit the provider community in implementing the new billing procedures.

In June 2005, the CMS issued CR 3890 which required the implementation of the ESRD 50/50 rule for carriers effective January 2006. During the preparation for implementation, the provider community has commented that business requirements relating to the use of Modifier 91 (Repeat Clinical Diagnostic Laboratory Test) was inconsistent with Current Procedural Terminology (CPT) procedures. We are adjusting the business requirements for proper use of Modifier 91.

B. **Policy:** Clinical diagnostic laboratory tests ordered by an ESRD facility must follow the accepted CPT guidelines. Specifically, if any single service is ordered and the specimen collected more than once in a single day, and the service is medically necessary, Modifier 91

must be used on any subsequent service being billed. When using CPT Modifier 91, it must be used without regard to whether it is a composite rate test (HCPCS Modifier CD), a composite rate test beyond the normal frequency (HCPCS Modifier CE), or a non-composite rate test (HCPCS Modifier CF).

II. BUSINESS REQUIREMENTS

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

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4101.1	Include any line item with a modifier 91 used in conjunction with the "CD," "CE," or "CF" modifier in the calculation of the 50/50 rule.					x	x			
4101.2	After the calculation of the 50/50 rule, services used to determine the payment amount may never exceed 22.					x	x			

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn 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 1 week of the availability of the provider education article. In addition, the provider									

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
2277.1.5	Delete this requirement
2277.1.6	Delete this requirement
2277.1.8	Delete this requirement
2813.5	Delete this requirement
2813.6	Delete this requirement
2813.7	Delete this requirement
2813.12	Delete this requirement
3890.1	Delete this requirement
3890.2	Delete this requirement
3890.3	Delete this requirement
3890.5	Delete this requirement

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: Assure that the Modifier 91 has no impact on the calculation of the 50/50 rule and that the system will not pay more than ATP22 on the laboratory fee schedule.

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2006 **Implementation Date:** April 3, 2006 **Pre-Implementation Contact(s):** Dan Layne (410)786-3320 **Post-Implementation Contact(s):** Regional Offices	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

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

40.6.1 – Automated Multi-Channel Chemistry (AMCC) Tests for ESRD Beneficiaries – F*I*s *and Carriers)*

(Rev. 733, Issued: 10-28-05, Effective: 01-01-06, Implementation: 04-03-06)

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*s* 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 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

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 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*d* 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: 1*2* services total, *5* non-composite rate tests, *6* composite rate tests beyond the frequency, 1 composite rate test; 1/1*2* = *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 6/01/0*6* 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 6/01/0*6* 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.