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Re-implementation of the AMCC Lab Panel Claims Payment System Logic

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PROVIDER TYPE AFFECTED

This MLN Matters® Article is for physicians, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 11248 informs MACs about the changes to editing within the claims processing system to enforce the National Correct Coding Initiative (NCCI) coding guidance. Make sure that your billing staffs are aware of these changes.

BACKGROUND

Section 1834A of the Act, as established by Section 216(a) of the Protecting Access to Medicare Act of 2014 (PAMA), required significant changes to how Medicare pays for Clinical Diagnostic Laboratory Tests (CDLTs) under the Clinical Laboratory Fee Schedule (CLFS). The Centers for Medicare & Medicaid Services (CMS) published the CLFS final rule "Medicare Clinical Diagnostic Laboratory Tests Payment System Final Rule" (CMS-1621-F at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/CLFS-Reglations-and-Notices/CMS-1621-F.html) in the Federal Register on June 23, 2016. The CLFS final rule implemented section 1834A of the Act. Under the CLFS final rule, reporting entities must report to CMS certain private payer rate information (applicable information) for their component applicable laboratories. The implementation of PAMA required Medicare to pay the weighted median of private payor rates for each separate HCPCS code.

Prior to PAMA implementation, CMS paid for certain chemistry tests using Automated Test Panels (ATPs) which used claims processing logic to apply a bundled rate to sets of these codes, depending on how many of these chemistry tests were ordered. Additionally, the claims processing system would not pay more than the associated panel Current Procedural Terminology (CPT) code if the tests were billed individually.

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This prior logic of using ATPs and rolling up payment amounts to not exceed the panel rate, no longer exists under PAMA guidelines. HCPCS codes include those from the AMA CPT Manual, that are in the category of Organ or Disease Oriented panels, which are panels that consist of groups of specified tests. Because CMS no longer has payment logic to roll up panel pricing for organ or disease-oriented panels (also known as Automated Multi-Channel Chemistry or AMCC tests), laboratories must report the HCPCS code for the AMCC panel test where appropriate and not report separately the tests that make up that panel.

Note the following:

- If you perform HCPCS codes 82040, 84075, 84450, 84460, 82247, 82248 AND 84155 for the same date of service (DOS), do not report them separately. Report organ disease panel code 80076 instead.
- If you perform codes 82330, 82435, 82374, 82565, 82947, 84132, 84295 AND 84520 for the same DOS. Report organ disease panel code 80047 instead.
- If you perform codes 82310, 82435, 82374, 82565, 82947, 84132, 84295 AND 84520 for the same DOS. Report organ disease panel code 80048 instead.
- If you perform codes 82040, 84075, 84450, 84460, 82247, 82310, 82435, 82374, 82565, 82947, 84132, 84155, 84295 AND 84520 for the same DOS. Report organ disease panel code 80053 instead.
- If you perform codes 82040, 82310, 82435, 82374, 82565, 82947, 84100, 84132, 84295 AND 84520 for the same DOS. Report organ disease panel code 80069 instead.
- If you perform codes 82465, 83718 AND 84478 for the same DOS. Report organ disease panel code 80061 instead.
- If you perform codes 82435, 82374, 84132 AND 84295 for the same DOS. Report organ disease panel code 80051 instead.

Note: Services are considered performed on the same DOS when the from/thru dates are equal (professional claims) or the tests have the same line item DOS (institutional claims).

If you do not follow the coding guidance in the above bullet points, your MAC will either return institutional claim lines to the provider (RTP) or return professional claims as unprocessable with the following messages:

- Claim Adjustment Reason Code (CARC) 236: This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements
- Remittance Advice Remarks Code (RARC) N657: This should be billed with the appropriate code for these services.
- Group Code: CO - Contractual Obligation

This instruction is consistent with recent changes in CMS's National Correct Coding Initiative (NCCI) manual. For example, if the individually ordered tests are cholesterol (CPT code 82465), triglycerides (CPT code 84478), and HDL cholesterol (CPT code 83718), report the service as a

lipid panel (CPT code 80061). If the laboratory repeats one of these component tests as a medically reasonable and necessary service on the same date of service, report the CPT code corresponding to the repeat laboratory test separately with modifier 91 appended. For additional information on coding for organ disease panels, please refer to the NCCI Policy Manual for Medicare Services for CY 2019 (https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html), Chapter I, Section N (Laboratory Panel) and Chapter X, Section C (Organ or Disease Oriented Panels).

CR11248 creates editing within the claims processing system to enforce the NCCI coding guidance.

ADDITIONAL INFORMATION

The official instruction, CR11248, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R4299CP.pdf.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

DOCUMENT HISTORY

Date of Change	Description
May 3, 2019	Initial article released.