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Related Change Request (CR) #: 4101

Related CR Release Date: October 28, 2005

Effective Date: January 1, 2006

Related CR Transmittal #: R733CP

Implementation Date: April 3, 2006

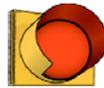
Repeat Tests for Automated Multi-Channel Chemistries for End Stage Renal Disease (ESRD) Beneficiaries

Note: This article was updated on February 21, 2013, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

Physicians, suppliers, and providers billing Medicare carriers and/or fiscal intermediaries (FIs) for services provided to Medicare ESRD beneficiaries

Provider Action Needed



STOP – Impact to You

This article is based on Change Request (CR) 4101 provides details regarding the payment policy for End Stage Renal Disease (ESRD)-related Automated Multi-Channel Chemistry (AMCC) Tests (i.e., the ESRD 50/50 rule), and clarifies a coding issue concerning repeat tests using the Current Procedure Terminology (CPT) modifier 91.

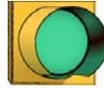


CAUTION – What You Need to Know

Clinical diagnostic laboratory tests ordered by an ESRD facility must follow accepted CPT guidelines. Specifically, **Modifier 91 must be used on any subsequent service** being billed if 1) any single service (same CPT code) is ordered (for the same beneficiary), and 2) the specimen is collected more than once in a single day, and the service is medically necessary. Also, any line item on a claim with a modifier 91 will be included into the calculation of the 50/50 rule, and after the calculation of the 50/50 rule, services used to determine the payment amount may never exceed 22.

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GO – What You Need to Do

Please see the *Background* section of this article for further details.

Background

ESRD 50/50 Rule

The Centers for Medicare & Medicaid Services (CMS) previously issued instructions to Medicare carriers regarding procedures to enforce compliance with the payment policy for ESRD-related Automated Multi-Channel Chemistry (AMCC) 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 the composite payment rate tests **versus** the number of covered 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 CR2813, CMS directed Medicare carriers to make the necessary systems changes to implement front-end edits in preparation for the standard system implementation of CR2813 in the January 2005 release.

Note: 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.

CR2813 also directed the carriers not to post any information concerning the business requirements associated with the implementation of CR2813 until receiving further guidance from CMS.

Business Requirements Relating to Modifier 91

In June 2005, CMS issued CR3890, which required the implementation of the ESRD 50/50 rule for Carriers, effective January 2006. During the preparation for implementation, the provider community commented that business requirements relating to the use of Modifier 91 (Repeat Clinical Diagnostic Laboratory Test) were **inconsistent** with Current Procedural Terminology (CPT) procedures. CMS is adjusting the business requirements for proper use of Modifier 91.

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A MLN Matters article, MM3890, is available for CR3890 at <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM3890.pdf> on the CMS website.

Therefore, CR4101 directs that clinical diagnostic laboratory tests ordered by an ESRD facility must follow accepted CPT guidelines. Specifically, **Modifier 91 must be used on any subsequent service** being billed if:

- Any single service (same CPT code) is ordered (for the same beneficiary); and
- The specimen is collected more than once in a single day; and
- The service is medically necessary.

In addition, when using CPT Modifier 91, it must be used without regard to whether it is a:

- Composite rate test (Healthcare Common Procedure Coding System (HCPCS) Modifier CD);
- Composite rate test beyond the normal frequency (HCPCS Modifier CE); or
- Non-composite rate test (HCPCS Modifier CF).

Note: Any claim with a modifier 91 will be included into the calculation of the 50/50 rule, and after the calculation of the 50/50 rule, services used to determine the payment amount may never exceed 22.

Additional Information

For complete details regarding CR4101, please see the official instruction issued to your carrier or intermediary regarding this change. That instruction may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R733CP.pdf> on the CMS website.

If you have any questions, please contact your carrier or intermediary at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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