
CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 372

Date: NOVEMBER 19, 2004

CHANGE REQUEST 3483

SUBJECT: Payment for Referred Laboratory Automated Multi-Channel Chemistry (AMCC) Tests

I. SUMMARY OF CHANGES: This transmittal modifies the payment guidelines for referred laboratory automated multi-channel chemistry (AMCC) tests. It instructs carriers to calculate the amount payable for each locality in which a test or panel is performed when one or more AMCC test/panel is referred to another laboratory for processing.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: April 1, 2005
IMPLEMENTATION DATE: April 4, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 not updated.)
(R = REVISED, N = NEW, D = DELETED) – (Only One Per Row.)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	16/90.3/Claims Processing Requirements for Panel and Profile Tests
R	16/90.3.1/History Display

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

X	Business Requirements
X	Manual Instruction
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

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

Attachment - Business Requirements

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SUBJECT: Payment for Referred Laboratory Automated Multi-Channel Chemistry (AMCC) Tests

NOTE: The VIPS shared system and associated Part B Carriers are waived from implementing this change request (CR) due to their upcoming transition to the MCS system. Carriers are required to implement the CR once they transition to MCS.

I. GENERAL INFORMATION

A. Background: In accordance with Pub 100-04, Medicare Claims Processing Manual, Chapter 16, §90, laboratory tests covered under Medicare may be billed either individually or as an organ/disease panel. The carrier/intermediary must group together the individual tests when billed separately, or as components of any organ/disease panels, and consider the price of all of the related AMCC tests performed on the same day by the same physician/supplier, for a particular beneficiary. (Medicare covers twenty-two laboratory AMCC tests, when reasonable and necessary. See Pub 100-04, Chapter 16, §90.2.)

Under the current payment guidelines for laboratory AMCC tests/panels, contractors do not distinguish between those tests/panels that were performed by the billing laboratory, and those tests/panels that were referred to another laboratory, and billed by the referring independent laboratory, when calculating the amounts payable.

B. Policy: Effective April 1, 2005, for all AMCC tests, carriers must calculate the amount payable for each locality in which a test or panel is performed when one or more AMCC test/panel is referred to another laboratory for processing. Carriers should use the following process to calculate the amounts payable for the individual AMCC tests and AMCC panels:

- A. Unbundle all panels to single lines representing individual AMCC tests, and identify duplicate tests within the claim. On concurrently processed claims, determine the total amount payable based on the combination of all AMCC tests billed by the same laboratory, for the same beneficiary, and for the same date of service.
- B. Check history for laboratory AMCC services provided by the same provider, to the same beneficiary, on the same day. Unbundle any panels. Identify duplicate services. Aggregate all nonduplicate services for pricing (include the submitted charge and paid amounts for both individually and paneled billed claims). If a single organ disease panel or a single chemistry panel contains the only AMCC test claims for that date of service, adjudicate as billed.
- C. Compare each line's submitted charge to the fee schedule for that code (including automated tests retrieved from history).
- D. Sum the comparisons of the line by line.

- E. Obtain the fee for all AMCC tests as a panel including all services in history. If organ disease (OD) panels are involved, this amount will include fees for nonautomated tests included in the OD panel.
- F. Carry forward the lesser of items D or E.
- G. For steps A-C above, include the following calculations to price the claim by locality, using the fee schedule amount for each locality, when one or more test has been referred to another laboratory for processing:

Use the **total number of allowable AMCC tests** (both referred and nonreferred) to calculate the amount payable for each test. For example, if three tests are performed within the local carrier's jurisdiction, and two are referred to another laboratory for processing, first determine the amount payable for the five tests in each payment jurisdiction. Divide the total fee schedule amount for all tests being priced by the total number of allowable AMCC tests (in this example, five tests). The result is the unit price for each test. Multiply this result by the total number of AMCC tests performed within each pricing jurisdiction. (In this example, three tests were performed in jurisdiction 1 and two tests were performed in jurisdiction 2). Repeat this process for each pricing jurisdiction. In this example, there are two pricing jurisdictions. In jurisdiction 1, the amount payable is calculated by dividing the total fee schedule amount for jurisdiction 1 by five, and multiplying the result by three. Similarly, the amount payable for jurisdiction 2 is calculated by dividing the total fee schedule amount for jurisdiction 2 by five, and multiplying the result by two. Sum the two results (i.e., jurisdiction 1 amount + jurisdiction 2 amount). Compare this **calculated amount to the amount determined in E** for the AMCC tests to determine the amount payable. (The amount payable is the lower of the fee schedule amount versus the submitted charges.)

- H. Carry forward the lesser of the fee schedule amount versus the submitted charges, as determined in item G.
- I. Subtract from item H any previous laboratory AMCC test (individual or paneled) or organ disease panel containing automated test payments. If nothing is payable on the claim, allow it with no payment.
- J. The amount payable is the total payable based on the combination of current and previously processed claims, less the total amount paid on the previous claim(s).
- K. If a claim is a CLIA reject from the CWF, recycle that claim through the payment process to recalculate payment.

(**NOTE:** These calculations are provided as an example only. Carriers and standard system maintainers have the flexibility to vary these procedures as long as they attain the same result.)

If none of the AMCC tests have been referred to another laboratory for processing, carriers should exclude item G in calculating the amounts payable for individual AMCC tests and AMCC panels. (See Publication 100-04, Chapter 16, §90.3.)

C. Provider Education: A Medlearn Matters 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 one week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin. 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.

II. BUSINESS REQUIREMENTS

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

Requirement Number	Requirements	Responsibility (place an "X" in the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CVF	
3483.1	Effective April 1, 2005, when one or more AMCC test that may be billed as a panel is referred to a laboratory that is located outside of the local carrier's jurisdiction, carriers shall calculate the amount payable for each test by locality, prorated by the total number of tests ordered (including both referred and nonreferred AMCC tests).			X			X			
3483.2	When no AMCC tests are referred to another laboratory for processing, carriers shall continue to follow the procedures in Publication 100-04, Chapter 16, §90.3 to price and pay claims for AMCC panels and individual AMCC tests.			X			X			

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

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: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

<p>Effective Date*: April 1, 2005</p> <p>Implementation Date: April 4, 2005</p> <p>Pre-Implementation Contact(s): Susan Webster, (410) 786-3384</p> <p>Post-Implementation Contact(s): Susan Webster, (410) 786-3384</p>	<p>Medicare contractors shall implement these instructions within their current operating budgets.</p>
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90.3 - Claims Processing Requirements for Panel and Profile Tests

(Rev. 372, Issued: 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

All test codes should be processed and stored in history as they are submitted. That is, if tests are submitted as individual CPT codes together and paid as a panel (see §90), the claim history data will reflect the individual codes and the panel used in pricing. All tests must maintain their identity as billed.

Prior to January 1, 1998, automated panel codes were adjudicated only on a line-by-line basis with application of the correct coding initiative (CCI) edits for duplicate detection.

Beginning with processing date January 1, 1998, when individual automated test codes are received, carriers and FIs do not combine them into panels for processing. The only instance in which they should be panel codes is when they are coded as such on the claim.

Panels must be processed line by line, and must be compared to other claims with automated test panels and/or single laboratory HCPCS codes in the current processing cycle, plus previous paid/processed claims. Therefore, any and all automated tests must be paid as a panel, but still retain their individual identity for duplicate detection and medical necessity review.

Carriers and FIs

1. Deny Duplicates. Deny duplicate services detected within the same processing cycle or stored in an automated history file. Consider claims that match on the following items as duplicates

- a. The service was performed by the same provider,
- b. For the same beneficiary, and
- c. For the same date of service.

2. Medical Necessity. Determine medical necessity. This process permits the identification of CPT codes subject to local medical review policies.

3. Process Claims. The processes shown below (A-K) should be followed to price and pay claims for automated panels (as defined in HCPCS) and individual tests. This does not replace or abridge any current procedures in place concerning the adjudication of claim. This is a general procedure for combining these services to attain the lowest pricing outcome. This display is an example only. System maintainers have the flexibility to vary these procedures as long as they attain the same result.

- A. Unbundle all panels to single lines representing individual *automated multi-channel chemistry (AMCC)* tests, and identify duplicate tests within the claim. On concurrently processed claims, determine the total amount payable based on

the combination of all *AMCC* tests billed by the same laboratory, *for the same beneficiary, and* for the same date of service.

- B. Check history for laboratory *AMCC* services provided *by the same provider, to the same beneficiary, on the same day*. Unbundle any panels. Identify duplicate services. Aggregate all nonduplicate services for pricing (include the submitted charge and paid amounts for both individually or paneled billed claims). If a single organ disease panel or a single chemistry panel contains the only *AMCC* test claims for that date of service, adjudicate as billed.
- C. *Compare each line's submitted charge to the fee schedule for that code (including automated tests retrieved from history).*
- D. *Sum the comparisons of the line by line.*
- E. *Obtain the fee for all AMCC tests as a panel including all services in history. If organ disease (OD) panels are involved, this amount will include fees for nonautomated tests included in the OD panel.*
- F. *Carry forward the lesser of items D or E.*
- G. *For steps A-C above, include the following calculations to price the claim by locality, using the fee schedule amount for each locality, when one or more test has been referred to another laboratory for processing:*

*Use the **total number of allowable AMCC tests** (both referred and nonreferred) to calculate the amount payable for each test. For example, if three tests are performed within the local carrier's jurisdiction, and two are referred to another laboratory for processing, first determine the amount payable for the five tests in each payment jurisdiction. Divide the total fee schedule amount for all tests being priced by the total number of allowable AMCC tests (in this example, five tests). The result is the unit price for each test. Multiply this result by the total number of AMCC tests performed within each pricing jurisdiction. (In this example, three tests were performed in jurisdiction 1 and two tests were performed in jurisdiction 2). Repeat this process for each pricing jurisdiction. In this example, there are two pricing jurisdictions. In jurisdiction 1, the amount payable is calculated by dividing the total fee schedule amount for jurisdiction 1 by five, and multiplying the result by three. Similarly, the amount payable for jurisdiction 2 is calculated by dividing the total fee schedule amount for jurisdiction 2 by five, and multiplying the result by two. Sum the two results (i.e., jurisdiction 1 amount + jurisdiction 2 amount). Compare this calculated amount to the submitted charges for the AMCC tests to determine the amount payable. (The amount payable is the lower of the fee schedule amount versus the submitted charges.)*

- H. *Carry forward the lesser of the fee schedule amount versus the submitted charges, as determined in item G.*

- I. Subtract from item *H* any previous laboratory *AMCC* test (individual or paneled) or organ disease panel containing automated test payments. If nothing is payable on the claim, allow it with no payment.
- J. The amount payable is the total payable based on the combination of current and previously processed claims, less the total amount paid on the previous claim(s).
- K. If a claim is a CLIA reject from the CWF, Recycle that claim through the payment process to recalculate payment.

(NOTE: These calculations are provided as an example only. Carriers and standard system maintainers have the flexibility to vary these procedures as long as they attain the same result.)

If none of the AMCC tests have been referred to another laboratory for processing, carriers should exclude item G in calculating the amounts payable for individual AMCC tests and AMCC panels.

90.3.1 - History Display

(Rev. 372, Issued: 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

When displaying claims payment for each CPT code in history, contractors apply the following rules:

1. If all component tests of any panel are allowed because the individual line item comparison is less than the fee (*as determined in item C above*), record the panel codes as determined on the line-by-line comparison.
2. If all component tests are paid based on the panel price, allocate the current payment proportionate to the amount submitted for each CPT code.
3. If any panel tests will be denied or there are previously paid automated laboratory tests (as indicated by a check of beneficiary history), allocate the current payment amount by allowed line proportionate to what was submitted for the current claim being processed.

For administration of pricing requirements and/or invalid coding policies, contractors must establish a processing sequence for concurrently processed claims based on ascending order of internal control number (ICN). In the case of pricing, they must process the “first claim” (i.e., lower CN) based solely on the billed codes on that claim, process the “second” claim based on a combination of the billed codes on both claims and pay the balance due after subtracting the amount paid on the “first” claim. In the case of unacceptable code combinations, contractors must deny the “second” claim.