CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 939	**Date: August 1, 2011**
	Change Request 7497

SUBJECT: Independent Laboratory Billing of Automated Multi-Channel Chemistry (AMCC) Organ Disease Panel Laboratory Tests for Beneficiaries who are not Receiving Dialysis for Treatment of End Stage Renal Disease (ESRD)

I. SUMMARY OF CHANGES: This change request (CR) sunsets the requirement for Independent Labs to bill separately for each individual AMCC lab test included in organ disease panel codes for ESRD eligible beneficiaries.

EFFECTIVE DATE: January 1, 2012
IMPLEMENTATION DATE: January 3, 2012

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
N/A	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

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:

One-Time Notification

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

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 939	Date: August 1, 2011	Change Request: 7497

SUBJECT: Independent Laboratory Billing of Automated Multi-Channel Chemistry (AMCC) Organ Disease Panel Laboratory Tests for Beneficiaries who are not Receiving Dialysis for Treatment of End Stage Renal Disease (ESRD)

Effective Date: **January 1, 2012**
Implementation Date: January 3, 2012

I. GENERAL INFORMATION

A. Background:

Prior to January 2011, Independent Laboratories (ILs) were paid according to the 50/50 rule payment calculation for Automated Multi-Channel Chemistry (AMCC) laboratory tests provided to beneficiaries who were eligible for Medicare under the End-Stage Renal Disease (ESRD) benefit. Editing was based on the beneficiary's eligibility for Medicare under the ESRD benefit. Additionally, under the 50/50 rule ILs were not allowed to bill organ disease panel codes (i.e., Healthcare Common Procedure Coding System (HCPCS) codes 80047, 80048, 80051, 80053, 80061, 80069, and 80076) because of the 50/50 rule payment calculation. ILs were required to bill for each individual laboratory test included in the organ disease panel and use modifiers CD, CE, or CF with each code to identify which tests were included in the composite rate and which were separately payable. See Change Request 6683 (Transmittal 661, issued April 5, 2010).

Since the implementation of the ESRD Prospective Payment System (PPS) on January 1, 2011, ILs are no longer able to bill Medicare directly for any AMCC laboratory test that is related to the treatment of ESRD as payment for that test is already included in the bundled rate paid to the dialysis facility. Consequently, the 50/50 rule payment calculation was discontinued for ILs. Claim editing was put in place that would allow ILs to bill (and be separately paid) for bundled laboratory tests performed on ESRD eligible patients so long as the service is not related to the treatment of ESRD. If the patient is not receiving dialysis treatment (for whatever reason), the IL may bill Medicare directly for any laboratory test it performs. However, while ILs can now be separately paid for individual laboratory tests performed on ESRD eligible patients who are not receiving dialysis, the editing that disallowed billing of organ disease panel codes for ESRD eligible beneficiaries remains active.

This change request (CR) sunsets the requirement for ILs to bill separately for each individual AMCC laboratory test included in organ disease panel codes for ESRD eligible beneficiaries. Organ disease panels will be paid under the Clinical Laboratory Fee Schedule and will not be subject to the 50/50 rule payment calculation when billed by Independent Laboratories.

B. Policy:

Effective January 1, 2012, contractors shall allow organ disease panel codes (i.e., HCPCS codes 80047, 80048, 80051, 80053, 80061, 80069, and 80076) to be billed by ILs for ESRD eligible beneficiaries when the beneficiary is not receiving dialysis treatment for any reason (e.g., post-transplant beneficiaries).

Contractors shall make payment for organ disease panels according to the Clinical Laboratory Fee Schedule and shall apply the normal ESRD PPS editing rules for IL claims described in Transmittal 2134, issued January 14, 2011. The aforementioned organ disease panel codes will be added to the list of bundled ESRD PPS laboratory tests in January 2012.

NOTE: The Internet Only Manual, Publication 100-04, Chapter 16, § 40.6 will be revised in a separate CR.

II. BUSINESS REQUIREMENTS 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	
7497.1	Effective for claim dates of service on and after January 1, 2012, CWF shall no longer apply the editing implemented by Change Request 6683 (business requirement 6683.4), which disallowed billing of organ disease panel codes 80047, 80048, 80051, 80053, 80061, 80069, and 80076 for ESRD-eligible beneficiaries.									X	
7497.2	CWF shall apply the claim editing rules for laboratory tests billed on the CMS-1500 as described in Change Request 7064 (Transmittal 2134, issued January 14, 2011) to organ disease panel codes 80047, 80048, 80051, 80053, 80061, 80069, and 80076.									X	
7497.3	Contractors shall note that organ disease panel codes 80047, 80048, 80051, 80053, 80061, 80069, and 80076 will be added to the list of laboratory tests included in the ESRD PPS bundled rate in the January 2012 quarterly update.	X			X					X	
7497.4	Contractors shall note that suppliers may continue billing for individual tests that are included in each of the panels mentioned in 7497.3. However, normal bundling and duplicate editing rules that prevent suppliers from billing both the panel code and corresponding individual test codes for the same beneficiary on the same date of service continue to apply.	X			X					X	

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	
7497.5	A provider education article related to this instruction will	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	
	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.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
7497.2	See business requirements 7064.41 – 7064.46.3

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

V. CONTACTS

Pre-Implementation Contact(s): Felicia Rowe at felicia.rowe@cms.hhs.gov or 410-786-5655.

Post-Implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs)*:

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.