CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 661	**Date March 23, 2010**
	Change Request 6683

Transmittal 586, dated October 30, 2009 is being rescinded and replaced by Transmittal 661, dated March 23, 2010. This CR is being rescinded and replaced to make a correction on BR 6683.3.1.2. We are replacing Reason Code 16 and Remark Code M78 with Reason Code 4. Remark Code M78 was discontinued. All other material remains the same.

Subject: Validating the Billing of End Stage Renal Disease (ESRD) 50/50 Rule Modifier

I. SUMMARY OF CHANGES: This Change Request (CR) creates the functionality in the Common Working File to validate billing instructions in the Internet Only Manual Publication 100-02, Chapter 11, Section 30.2.2 and Publication 100-04, Chapter 16, Section 40.6.1 in regards to identifying the appropriate modifier when ordering Automated Multi-Channel Chemistry (AMCC) ESRD-related tests and provides billing instructions regarding use of the ESRD 50/50 rule modifiers CD, CE, and CF. The April 5, 2010 effective date is to be for claims processed on or after April 5, 2010.

New / Revised Material
Effective Date: For claims processed on or after April 5, 2010
Implementation Date: April 5, 2010

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:
SECTION A: For Fiscal Intermediaries and Carriers:
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.

IV. ATTACHMENTS:

One-Time Notification

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

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 661	Date: March 23, 2010	Change Request: 6683

Transmittal 586, dated October 30, 2009 is being rescinded and replaced by Transmittal 661, dated March 23, 2010. This CR is being rescinded and replaced to make a correction on BR 6683.3.1.2. We are replacing Reason Code 16 and Remark Code M78 with Reason Code 4. Remark Code M78 was discontinued. All other material remains the same.

SUBJECT: Validating the Billing of End Stage Renal Disease (ESRD) 50/50 Rule Modifier

Effective Date: For claims processed on or after April 5, 2010

Implementation Date: April 5, 2010

I. GENERAL INFORMATION

A. Background:

This Change Request (CR) creates the functionality in the Common Working File to validate billing instructions in the Internet Only Manual Publication 100-02, Chapter 11, Section 30.2.2 and Publication 100-04, Chapter 16, Section 40.6.1 in regards to identifying the appropriate modifier when ordering Automated Multi-Channel Chemistry (AMCC) ESRD-related tests and provides billing instructions regarding use of the ESRD 50/50 rule modifiers CD, CE, and CF. The payment of certain ESRD laboratory services performed by an independent laboratory is included in the composite rate calculation for ESRD facilities. When billing Medicare for AMCC ESRD-related tests, laboratories must indicate which tests are or are not included within the ESRD facility composite rate to ensure proper reimbursement.

The ESRD 50/50 rule classifies AMCC ESRD-related tests according to the following categories:

1. AMCC test ordered by an ESRD facility (or MCP physician) that is part of the composite rate and is not separately billable;
2. AMCC test 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; and
3. AMCC test ordered by an ESRD facility (or MCP physician) that is not part of the composite rate and is separately billable.

When billing for AMCC ESRD-related tests, the laboratory must include the appropriate modifier for each test, as follows:

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;
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; or
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.

The proportion (or percentage) of composite tests to non-composite tests billed is used to determine whether separate payment may be made for all tests performed on the same day for the same beneficiary.

Refer to IOM Pub 100-04, Chapter 16, and Section 90.2 for the chart which identifies the AMCC ESRD-related tests or refer to the attachment chart to this transmittal.

Note: The ESRD clinical diagnostic laboratory tests identified with modifiers "CD", "CE" or "CF" may not be billed as organ disease panels and shall be returned as unprocessable.

B. Policy: Physicians, providers, and suppliers billing AMCC ESRD-related tests to Medicare on a CMS-1500 claim form or the ANSI X12N 837P electronic claim must report CD, CE, or CF modifiers for each test. If at least one of the three modifiers is not shown for one of the AMCC ESRD-related test codes, all AMCC ESRD-related test codes on the claim will be returned as unprocessable.

In the case when an organ disease panel (i.e., 80076, 80047, 80048, 80053, 80069, 80061, or 80051) is billed on a claim regardless of whether CD, CE, or CF modifier is used, the claim shall be returned as unprocessable.

Contractors and CWF shall refer to Attachment 1 for a list of AMCC ESRD-related tests or Publication 100-04, Chapter 16, and Section 90.2 for the chart listing AMCC ESRD-related tests. The HCPC codes for the AMCC tests are located on the far left column of the chart.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

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	
6683.1	CWF shall accept the claim as submitted if it is determined the beneficiary is NOT ESRD eligible.									X	
6683.2	CWF shall accept the claim as submitted if it is determined the ordering physician is NOT MCP physician.									X	
6683.3	CWF shall check the CPT (HCPCS) code(s) on the claim and verify if it is an AMCC ESRD-related test(s) claim.									X	
6683.3.1	CWF shall verify and process on an AMCC service if all conditions below are met: A. the beneficiary is ESRD eligible based on Master Beneficiary Record; B. the ordering physician is an MCP physician; and C. one of the 50/50 rule modifiers (CD, CE, or CF) is included on each HCPCS code for the AMCC ESRD-related test. (Each AMCC ESRD-related test codes must have a modifier)									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	
	Otherwise CWF shall reject the claim with a new CWF error code.										
6683.3.1.2	Upon receipt of CWF reject, the Shared System Maintainers or contractors shall return the claim as unprocessable using Reason Code 4 "The procedure code is inconsistent with the modifier used or a required modifier is missing".	X			X						
6683.4	CWF shall create a second new CWF error code and reject when all conditions below are met: A. the beneficiary is ESRD eligible based on Master Beneficiary Record; B. the ordering physician is an MCP physician; and C. organ disease panel code (80076, 80047, 80048, 80053, 80069, 80061, or 80051) is present with or without 50/50 rule modifiers CD,CE, or CF.									X	
6683.4.1	Upon receipt of CWF reject, the Shared System Maintainers or contractors shall return the claim as unprocessable and use Reason Code 4, "The procedure code is inconsistent with the modifier used or a required modifier is missing" along with Remark code N56, "Procedure code billed is not correct/valid for the services billed or the date of services billed."	X			X						
6683.5	CWF shall allow override capability on both new error codes.									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	
6683.6	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of	X			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	
	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:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	CR 2813, 3609, 3890

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

V. CONTACTS

Pre-Implementation Contact(s): Wendy Knarr at Wendy.Knarr@cms.hhs.gov or by dialing relay 711, then have agent call Wendy at 410-786-0843 or/and Felicia Rowe at Felicia.Rowe@cms.hhs.gov or 410-786-5655.

Post-Implementation Contact(s): Your Appropriate RO

VI. FUNDING

Section A: 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.

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.

Attachment – CY 2009: Chemistry Panels

CY 2009
Chemistry Panels

ATTACHMENT 1			Hepatic Function Panel	Basic Metabolic	Basic Metabolic	Comprehensive Metabolic	Renal Function Panel	Lipid* Panel	Electrolyte Panel
			80076	*80047*	*80048*	*80053*	*80069*	*80061*	*80051*
	Chemistry	**CPT Code**							
1	Albumin	82040	X			X	X		
2	Alkaline phosphatase	84075	X			X			
3	ALT (SGPT)	84460	X			X			
4	AST (SGOT)	84450	X			X			
5	Bilirubin, total	82247	X			X			
6	Bilirubin, direct	82248	X						
7	Calcium	82310			X	X	X		
8	Chloride	82435		X	X	X	X		X
9	Cholesterol	82465						X	
10	CK, CPK	82550							
11	CO2 (bicarbonate)	82374		X	X	X	X		X
12	Creatinine	82565		X	X	X	X		
13	GGT	82977							
14	Glucose	82947		X	X	X	X		
15	LDH	83615							
16	Phosphorus	84100					X		
17	Potassium	84132		X	X	X	X		X
18	Protein, total	84155	X			X			
19	Sodium	84295		X	X	X	X		X
20	Triglycerides	84478						X	
21	Urea nitrogen (BUN)	84520		X	X	X	X		
22	Uric Acid	84550							
23	Calcium, Ionized	82330		X					

* These chemistry services are billed with Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) 83718