CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 4299	**Date: May 3, 2019**
	Change Request 11248

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

I. SUMMARY OF CHANGES: This CR creates editing within the claims processing system to enforce the NCCI coding guidance.

EFFECTIVE DATE: January 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 7, 2019

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
R	16/90/.1.1/Automated Test Listing
R	16/90/.2/Organ or Disease Oriented Panels
R	16/90/.3/Claims Processing Requirements for Panel and Profile Tests
R	16/90/.1/Laboratory Tests Utilizing Automated Equipment
R	16/90/.3.1/History Display
R	16/90/.5/Special Processing Considerations

III. FUNDING:
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:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 4299	Date: May 3, 2019	Change Request: 11248

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

EFFECTIVE DATE: January 1, 2019
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I. GENERAL INFORMATION

A. 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 CLFS. The CLFS final rule "Medicare Clinical Diagnostic Laboratory Tests Payment System Final Rule" (CMS-1621-F) was published 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 CPT code if the tests were billed individually.

B. Policy: This prior logic of using Automated Test Panels and rolling up of payment amounts to not exceed the panel rate no longer exists under PAMA guidelines. HCPCS codes include those from the AMA Current Procedural Terminology (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 shall report the HCPCS code for the AMCC panel test where appropriate and not report separately the tests that make up that panel.

This is also 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), the service shall be reported 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, the CPT code corresponding to the repeat laboratory test may be reported separately with modifier 91 appended. For additional information on coding for these codes, 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);

• Chapter X, Section C (Organ or Disease Oriented Panels)

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

Therefore to ensure correct coding of laboratory claims, effective upon implementation of this instruction, providers and suppliers are required to submit all AMCC laboratory test HCPCS for the same beneficiary, performed on the same date of service on the same claim. This billing policy applies when:

a). Submitting a complete organ disease panel; or

b). Submitting individual component tests of an organ disease panel when all components of the panel were not performed.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11248.1	Shared System Maintainers shall create an edit which will identify incoming claims containing all individual component lab test Healthcare Common Procedure Coding System (HCPCS) codes that are included in organ disease panel 80076. If HCPCS codes 82040, 84075, 84450, 84460, 82247, 82248 and 84155 are all reported on the same claim with the same date of service (DOS), the edit shall return the applicable lines to provider (RTP) (FISS) or return the applicable lines as unprocessable (MCS). 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).		X			X	X			
11248.2	Shared System Maintainers shall create an edit which will identify incoming claims containing all individual component lab test HCPCS codes that are included in organ disease panel 80047 - If HCPCS codes 82330, 82435, 82374, 82565, 82947, 84132, 84295 and 84520 are all reported on the same claim with the same DOS, the edit shall RTP (FISS) the applicable lines or return the applicable lines as unprocessable (MCS). 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).		X			X	X			
11248.3	Shared System Maintainers shall create an edit which will identify incoming claims containing all individual component lab test HCPCS codes that are included in organ disease panel 80048 - If HCPCS codes 82310,		X			X	X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	82435, 82374, 82565, 82947, 84132, 84295 and 84520 are all reported on the same claim with the same DOS, the edit shall RTP (FISS) the applicable lines or return the applicable lines as unprocessable (MCS). 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).									
11248.4	Shared System Maintainers shall create an edit which will identify incoming claims containing all individual component lab test HCPCS codes that are included in organ disease panel 80053 - If HCPCS codes 82040, 84075, 84450, 84460, 82247, 82310, 82435, 82374, 82565, 82947, 84132, 84155, 84295 and 84520 are all reported on the same claim with the same DOS, the edit shall RTP (FISS) the applicable lines or return the applicable lines as unprocessable (MCS). 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).		X			X	X			
11248.5	Shared System Maintainers shall create an edit which will identify incoming claims containing all individual component lab test HCPCS codes that are included in organ disease panel 80069 - If HCPCS codes 82040, 82310, 82435, 82374, 82565, 82947, 84100, 84132, 84295 and 84520 are all reported on the same claim with the same DOS, the edit shall RTP (FISS) the applicable lines or return the applicable lines as unprocessable (MCS). 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).		X			X	X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11248.6	Shared System Maintainers shall create an edit which will identify incoming claims containing all individual component lab test HCPCS codes that are included in organ disease panel 80061 - If HCPCS codes 82465, 83718 and 84478 are all reported on the same claim with the same DOS, the edit shall RTP (FISS) the applicable lines or return the applicable lines as unprocessable (MCS). 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).		X			X	X			
11248.7	Shared System Maintainers shall create an edit which will identify incoming claims containing all individual component lab test HCPCS codes that are included in organ disease panel 80051 - If HCPCS codes 82435, 82374, 84132 and 84295 are all reported on the same claim with the same DOS, the edit shall RTP (FISS) the applicable lines or return the applicable lines as unprocessable (MCS). 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).		X			X	X			
11248.8	Shared System Maintainers shall include all claim lines in the editing criteria identified in requirements 1-7. NOTE: This means there are no exceptions regardless of coverage of the line or if any modifiers are reported on the line.					X	X			
11248.9	FISS shall set the edits in requirements 1-7 to apply only to types of bill (TOB) 12x, 13x, 14x, and 85x.					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11248.10	Shared System Maintainers shall make the edits created by requirements 1-7 overrideable.					X	X			
11248.11	For the editing created by requirements 1-7, MACs shall RTP (Part A) / return as unprocessable (Part B) claims for correct billing of the lab panel HCPCS code by the providers/suppliers.	X	X							
11248.11.1	MACs shall return as unprocessable (Part B) claims for correction with the following messages: 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. RARC N657: This should be billed with the appropriate code for these services. Group Code: CO - Contractual Obligation		X							
11248.12	Contractors shall end-date any local event editing previously implemented so as to coincide with the implementation date of this CR.	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
11248.13	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects	X	X			

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Vickie Poff, 410-786-0836 or vickie.poff1@cms.hhs.gov , Sarah Harding, sarah.harding@cms.hhs.gov , Eric Coulson, 410-786-3352 or eric.coulson@cms.hhs.gov , Felicia Rowe, 410-786-5655 or Felicia.Rowe@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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.

ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 16 - Laboratory Services

90.1 - Laboratory Tests Utilizing Automated Equipment
(Rev. 4299; Issued: 05-03-19; Effective: 01-01-19; Implementation: 10-07-19)
B3-5114, HO-437, A3-3628

Clinical laboratory tests are covered under Medicare if they are reasonable and necessary for the diagnosis or treatment of an illness or injury. Because of the numerous technological advances and innovations in the clinical laboratory field and the increased availability of automated testing equipment, no distinction is generally made in determining payment for individual tests because of either (1) the sites where the service is performed, or (2) the method of the testing process used, whether manual or automated. Whether the test is actually performed manually or with automated equipment, the services are considered similar and the payment is the same.

90.1.1 - Automated Test Listing
(Rev. 4299; Issued: 05-03-19; Effective: 01-01-19; Implementation: 10-07-19)
B3-5114, HO-437, A3-3628, PMs AB-97-5, AB-97-7, AB-97-17

Profiles are specific groupings of blood chemistries that enable physicians to more accurately diagnose their patients' medical problems. While the component tests in automated profiles may vary somewhat from one laboratory to another, or from one physician's office or clinic to another, in order to develop appropriate payment amounts, A/B MACs (A) and (B) group together those profile tests that can be performed at the same time on the same equipment. The A/B MAC (A) or (B) must group together the individual tests in the profile when billed separately and consider the price of the related automated profile test. Payment cannot exceed the lower of the profile price or the totals of the prices of all the individual tests. (This rule is applicable also if the tests are done manually.) The profile HCPCS code and each individual test is priced at the lower of the billed charge or the fee amount; and payment is made at the lower of the profile/panel price or the total of the prices for all covered components.

Payment is made only for those tests in an automated profile that meet Medicare coverage rules. Where only some of the tests in a profile of tests are covered, payment cannot exceed the amount that would have been paid if only the covered tests had been ordered. For example, the use of the 12-channel serum chemistry test to determine the blood sugar level in a proven case of diabetes is unreasonable because the results of a blood sugar test performed separately provide the essential information. Normally, the payment allowance for a blood sugar test is lower than the payment allowance for the automated profile of tests. In no event, however, may payment for the covered tests exceed the payment allowance for the profile.

However, the A/B MAC (B) prices and pays the 1-22 automated multi-channel chemistry tests tested in §90.2 at the lowest possible amount in accordance with §90.3.

As of January 1, 2018, the profiles referenced in the above section are no longer recognized by Medicare. The Protecting Access to Medicare Act of 2014 requires Medicare to pay a weighted median collected from private payor rates for each HCPCS code on the CLFS. Therefore the automated profiles described above are no longer used to pay for the automated profiles of tests.

90.2 - Organ or Disease Oriented Panels

(Rev. 4299; Issued: 05-03-19; Effective: 01-01-19; Implementation: 10-07-19)

*Prior to January 1, 2018, o*rgan or disease panels must be paid at the lower of the billed charge, the fee amount for the panel, or the sum of the fee amounts for all components. Payment for the total panel may not exceed the sum total of the fee amounts for individual covered tests. All Medicare coverage rules apply.

The Medicare shared systems must calculate the correct payment amount. The CMS furnishes fee prices for each code but the A/B MAC (A) or (B) system must compare individual codes billed with codes and prices for related individual tests. (With each HCPCS update, HCPCS codes are reviewed and the system is updated). Once the codes are identified, A/B MACs (A) and (B) publish panel codes to providers.

The only acceptable Medicare definition for the component tests included in the CPT codes for organ or disease oriented panels is the American Medical Association (AMA) definition of component tests. The CMS will not pay for the panel code unless all of the tests in the definition are performed. If the laboratory has a custom panel that includes other tests, in addition to those in the defined CPT or HCPCS panels, the additional tests, are billed separately in addition to the CPT or HCPCS panel code.

NOTE: If a laboratory chooses, it can bill each of the component tests of these panels individually, but payment will be based upon the above rules.

Effective for claims with dates of service on or after January 1, 2019, laboratories shall bill the HCPCS panel test code and not unbundle the individual components if all components of the HCPCS panel are performed. Claims will be returned as unprocessable/rejected if the HCPCS panel test code is not billed. Providers and suppliers are required to submit all AMCC laboratory test HCPCS for the same beneficiary, performed on the same date of service on the same claim. This billing policy applies when:

a). Submitting a complete organ disease panel; or

b). Submitting individual component tests of an organ disease panel when all components of the panel were not performed.

TABLE OF CHEMISTRY PANELS

		Hepatic Function Panel 80076	**Basic Metabolic Panel** (Calcium, ionized) **80047**	**Basic Metabolic Panel** (Calcium, total) **80048**	**Comprehensive Metabolic Panel 80053**	**Renal Function Panel 80069**	**Lipid[1] Panel 80061**	**Electrolyte Panel 80051**
Chemistry	**CPT**							
Albumin	82040	X			X	X		
Alkaline phosphatase	84075	X			**X**			
ALT (SGPT)	84460	X			X			
AST (SGOT)	84450	X			X			
Bilirubin, total	82247	X			X			
Bilirubin, direct	82248	X						
Calcium	82310			X	X	X		
Calcium ionized	82330		X					
Chloride	82435		X	X	X	X		X
Cholesterol	82465						X	
CK, CPK	82550							
CO2 (bicarbonate)	82374		X	X	X	X		X

[1] CPT code 83718 is billed with Organ/Disease Panel 80061 but is not included in the AMCC bundling.

		Hepatic Function Panel 80076	**Basic Metabolic Panel** (Calcium, ionized) **80047**	**Basic Metabolic Panel** (Calcium, total) **80048**	**Comprehensive Metabolic Panel 80053**	**Renal Function Panel 80069**	**Lipid[1] Panel 80061**	**Electrolyte Panel 80051**
Chemistry	**CPT**							
Creatinine	82565		X	X	X	X		
GGT	82977							
Glucose	82947		X	X	X	X		
LDH	83615							
Phosphorus	84100					X		
Potassium	84132		X	X	X	X		X
Protein	84155	X			X			
Sodium	84295		X	X	X	X		X
Triglycerides	84478						X	
Urea nitrogen (BUN)	84520		X	X	X	X		
Uric Acid	84550							

90.3 - Claims Processing Requirements for Panel and Profile Tests

(Rev. 4299; Issued: 05-03-19; Effective: 01-01-19; Implementation: 10-07-19)

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.

As of January 1, 1998, when individual automated test codes are received, A/B MACs (A) and (B) *did* not combine them into panels for processing. The only instance in which they should be panel codes is when they *were* coded as such on the claim.

Beginning January 1, 2018, Medicare does not recognize automated test panels, unless a panel has its own CPT code, as described in section 90.2.

A/B MACs (A) and (B)

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. *For claims with dates of service prior to January 1, 2019, t*he 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 A/B MAC (A)'s or (B)'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. A/B MACs (A) and (B) and shared 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, A/B MACs (A) and (B) should exclude item G in calculating the amounts payable for individual AMCC tests and AMCC panels.

90.3.1 - History Display

(Rev. 4299; Issued: 05-03-19; Effective: 01-01-19; Implementation: 10-07-19)

*Prior to January 1, 2018, w*hen displaying claims payment for each CPT code in history, A/B MACs (A) and (B) 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, A/B MACs (A) and (B) 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, A/B MACs (A) and (B) must deny the "second" claim.

90.5 - Special Processing Considerations

(Rev. 4299; Issued: 05-03-19; Effective: 01-01-19; Implementation: 10-07-19)

PM AB-97-17

To order any of the 2*3* automated tests, a physician may select individual tests or the panel. A physician may order a mix of panels and individual tests. The physician should review what tests are in each panel and not order individual tests that might duplicate tests in the panel. Medicare denies duplicate tests.

Specialists are not, based on their specialty, restricted to ordering certain panels or individual tests. The physician (general practitioner or specialist) should identify which tests he/she requires; and, if the tests match a grouping, order the appropriate panel.

Claimants should use the QP modifier with the single ordering of tests or when a single code is available for groupings of tests. This modifier indicates that the claimant has documentation on file showing that the laboratory test(s) was ordered individually or ordered as a CPT-recognized panel