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Medicare to Re-implement AMCC Lab Panel Claims Payment System Logic

On May 3, 2019 CMS issued Change Request 11248, which re-implements the Automated Multi-Channel Chemistry (AMCC) Lab Panel Claims Payment System Logic. This logic was introduced in 2017 but was suspended beginning CY 2018, due to the Protecting Access to Medicare Act of 2014 (PAMA). PAMA required significant changes to how Medicare pays for Clinical Diagnostic Laboratory Tests (CDLTs) under the Clinical Laboratory Fee Schedule (CLFS). Under PAMA, reporting entities must report to CMS certain private payer rate 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, as one National fee schedule rate rather than individual rates per state.

Prior to PAMA, CMS paid for certain chemistry tests using Automated Test Panels (ATPs). ATPs used claims processing logic to apply a bundled rate to sets of these codes based off how many ATPs were ordered. The claims processing system would not pay more for all ATPs than the associated CPT Panel (80047-80081). Any duplicated chemistry tests across ATPs or separately billed without a 91 modifier are not counted in the ATP test total. Below will further illustrate the logic and the effect on reimbursement. The Ohio rate of the 2017 CLFS is used for this demonstration, as the 2019 CLFS has not been updated with ATP entries as of the time of this article.

Example

A lab receives an order for a Comprehensive Metabolic Panel (80053) and a Lipid Panel (80061). Both panels are processed, results sent to the referring provider and a claim is sent to Medicare for HCPCS 80053 and 80061. The 2017 CLFS indicates payment for each HCPCS code as:

80053	$14.49
80061	$17.45
Total	**$31.94**

Under the ATP payment methodology, payment will be determined based off the total number of unique chemistry tests performed. Medicare will first strip each panel into its component codes as follows:

80053	**HCPCS**	**80061**	**HCPCS**
	82040		82465
	82247		83718
	82310		84478
	82374		
	82435		
	82565		
	82947		
	84075		
	84132		
	84155		
	84295		
	84460		
	84450		
	84520		

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Next, Medicare identifies all HCPCS within those panels that are defined as Automated Multi-channel Chemistry tests. That list is as follows and tests within the example are highlighted:

Albumin	82040
Alkaline Phosphatase	84075
ALT (SGPT)	84460
AST (SGOT)	84450
Bilirubin, Total	82247
Bilirubin, Direct	82248
Calcium	82310
Calcium Ionized	82330
Chloride	82435
Cholesterol	82465
CK, CPK	82550
CO2 (bicarbonate)	82374
Creatinine	82565
GGT	82977
Glucose	82947
LDH	83615
Phosphorus	84100
Potassium	84132
Protein	84155
Sodium	84295
Triglycerides	84478
Urea Nitrogen (BUN)	84520
Uric Acid	84550

There are 16 AMCC tests identified within the 2 panels ordered, but 17 total tests make up these panels. Because of this, Medicare will identify the appropriate ATP on the fee schedule and determine the fee schedule rate for the 1 test that is not a part of the ATP bundling. The appropriate ATP is highlighted below:

ATP02	$6.20
ATP03	$6.20
ATP04	$6.20
ATP05	$6.20
ATP06	$7.48
ATP07	$8.67
ATP08	$10.06
ATP09	$11.22
ATP10	$11.91
ATP11	$12.12
ATP12	$12.39
ATP16	$14.49
ATP18	$14.60
ATP19	$15.18
ATP20	$15.66
ATP21	$16.16
ATP22	$16.64
ATP23	$16.64

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Since there are 16 AMCCs, these tests are paid at ATP16 (13-16 AMCCs). Reimbursement for the 1 test that is part of the ordered panels but not AMCCs is determined by the CLFS rate for the test. That rate is:

83718	$11.24

Combined, Medicare will pay $25.73 for the ordered and resulted 80053 and 80061. That is a 19% reduction from the originally expected rate of $31.94 for both panels, as they are paid today. The reduction in reimbursement can be even more impactful when 2 panels are ordered together that have overlapping AMCCs, as Medicare will not count the same test twice in its ATP calculation.

Further impact will be felt for labs that process an ordered panel along with a stand-alone order for another AMCC. A Comprehensive Metabolic Panel (80053), for example, is made up of 14 AMCCs. This test will pay under ATP16, which allows for 2 more tests to be absorbed in that bundle without any higher reimbursement. There are other considerations, such as send-out tests or repeated tests for the same date of service. The full instructions from CMS to the MACs can be found here.

We are currently in the 2nd reporting period for PAMA and, if we've learned anything, clinical labs and outreach labs saw drastic reductions in the CLFS after the first data period review. By statute, CMS cannot lower any clinical laboratory code by more than 10% any given year, but this payment policy will allow for even further reductions in reimbursement in advance of the next PAMA related cuts.

This policy is scheduled for implementation on 10/7/2019, but has an effective date of 1/1/2019 (by date of service). There was no indication as to whether Medicare will reprocess claims from 1/1/2019-10/7/19. APS has reached out to CMS for clarification on that matter, as it could lead to large refunds owed by many labs. If you have any questions regarding this, please contact your Practice Manager.