Molecular Codes and More:
What your Lab Should Know to Get Speedy and Accurate Payment

Charles Root, Ph.D. CodeMap, LLC
Overview

- How the new Molecular Pathology codes work
- The Palmetto MolDx Program
- Coverage for Molecular Pathology Procedures
- How are Medicare payments being set for MoPath codes
- How Multi-Analyte Assays with Algorithmic Analysis (MAAAs) fit into the coding system
- How to respond to inadequate or denied payments
- Future challenges: Coverage and New Technology
How the New MoPath Codes Work
A Brief History of MoPath Coding . . .

- Payers were unhappy with “stacked” procedure codes which did not show what they were paying for
- The AMA created new, gene and procedure specific codes in 2012 CPT
- CMS delayed implementation of the new codes until 2013
- Medicare decided to use “gap-filling” to set payment levels for all MoPath codes during 2013
- The gap-filling process is now under way . . . .
The MoPath Coding System

- **Tier 1 codes** include individual analytes tested in sufficient volumes to warrant a specific Category 1 CPT code.

- **Tier 2 codes** represent medically useful procedures performed in lower volumes.

- Both Tier 1 and Tier 2 codes include essentially all analytical services required to perform the test (i.e., cell lysis, nucleic acid stabilization, extraction, digestion, amplification, detection and interpretation)
Tier 1 Code Format

81XXX  Gene abbreviation (gene name) (associated disease) gene analysis, type of variant tested, (examples of variants)

Example:

81200  ASPA (aspartoacylase) (e.g., Canavan disease) gene analysis, common variants (e.g., E285A, Y231X)

The unit of service is assumed to be 1 for Tier 1 assays
Tier 2 MoPath Codes

- **Tier 2 codes** are arranged by the level of technical resources required to perform the test.

- There are nine levels of service (81400 - 81408).

- Report the appropriate level that includes the specific analyte listed after the code descriptor.

- However, Tier 2 codes cannot be self-assigned!

*In other words, if the gene/procedure is not listed under a specific Tier 2 code in the CPT, that code cannot be reported.*
Tier 2 Code Format

8140X Molecular pathology procedure, Level 1-9 (e.g., types of analytical studies- e.g., number of SNP’s, exons, sequences, etc.)

Gene abbreviation 1 (gene name) (e.g., disease associations), type of variants included, etc.

Gene abbreviation 2 (gene name) (e.g., disease associations), type of variants included, etc.

Etc.
Examples of Tier 2 Service Levels:

- **81400** Molecular pathology procedure, **Level 1** (e.g., identification of single germline variant [e.g., SNP] by techniques such as restriction enzyme digestion or lysis)

- **81404** Molecular pathology procedure, **Level 5** (e.g., analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)

- **81408** Molecular pathology procedure, **Level 9** (e.g., analysis of >50 exons in a single gene by DNA sequence analysis)
Tier 2 Code Examples

81408 Molecular pathology procedure, Level 9 (e.g., analysis of > 50 exons in a single gene by DNA sequence analysis)

- *FBN1* (*fibrillin 1*) (e.g., Marfan syndrome), full gene sequence

- *NF1* (*neurofibromin 1*) (e.g., neurofibromatosis, type 1), full gene sequence

- *RYR1* (*ryanodine receptor 1. skeletal*) (e.g., malignant hyperthermia), full gene sequence

Etc.
Getting your gene assay listed as a Tier 2 code . . .

- Request a CPT code change from the AMA
- Editorial Panel meetings to consider changes are held in May, Oct and Feb
- Deadlines for application are 3 months prior to each meeting
- Prior to Panel Meeting, Molecular Pathology Advisory Group (MPAG) reviews requests for:
  - clinical validity,
  - descriptor accuracy,
  - placement in appropriate Tier 2 level.
Additional Criteria for Inclusion in the CPT as a Category I, Tier 2 Code

- Demonstrated relationship between biomarker and phenotype (i.e., clinical validity) in published US literature
- At least two U.S. laboratories are performing the analysis, unless proprietary (e.g., intellectual property) issues exist
# Growth in Tier 2 Procedures

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Complexity</th>
<th>Tests in 2012 CPT</th>
<th>Tests in 2013 CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>81400</td>
<td>Level 1</td>
<td>19</td>
<td>27</td>
</tr>
<tr>
<td>81401</td>
<td>Level 2</td>
<td>20</td>
<td>48</td>
</tr>
<tr>
<td>81402</td>
<td>Level 3</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>81403</td>
<td>Level 4</td>
<td>8</td>
<td>20</td>
</tr>
<tr>
<td>81404</td>
<td>Level 5</td>
<td>18</td>
<td>42</td>
</tr>
<tr>
<td>81405</td>
<td>Level 6</td>
<td>11</td>
<td>53</td>
</tr>
<tr>
<td>81406</td>
<td>Level 7</td>
<td>12</td>
<td>61</td>
</tr>
<tr>
<td>81407</td>
<td>Level 8</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td>81408</td>
<td>Level 9</td>
<td>4</td>
<td>11</td>
</tr>
</tbody>
</table>
Coding Unlisted MoPath Procedures

- If a specific gene analysis procedure is not present as a Tier 1 code or listed under a Tier 2 code, the following unlisted code must be reported:
  - 81479 Unlisted molecular pathology procedure
- This code (like all unlisted CPT codes) does not appear on Medicare fee schedules and is paid at the discretion of the Medicare contractor or commercial payer.
Use of “eg” and “ie” in Molecular Pathology Code Descriptions

- **ie** means “that is” or “in other words”. If the content of a parenthetical that begins with “ie,” is not met, the code can not be used.

- For example,
  - 81245 FLT3 (*fms*-related tyrosine kinase 3) (*eg*, acute myeloid leukemia), gene analysis, internal tandem duplication variants (ie, exons 14, 15)
  - **This code requires** analysis for internal tandem duplication variants in exons 14 and 15.
Use of “eg” and “ie” in Molecular Pathology Code Descriptions

- **eg** means “for example”. A parenthetical that begins with “eg,” explains but does not restrict the code’s use to what is included in the parenthetical.

- For example,
  - 81205 DCKDHB (*branched-chain keto acid dehydrogenase E1, beta polypeptide*) (*eg, Maple syrup urine disease*) gene analysis, common variants (*eg, R183P, G278S, E422X*)
  - This code **includes** analysis for R183P, G278S, E422X or any number of other common variants. The code specifies variants (plural), so more than one variant must be tested to use this code.
Reporting the Interpretation of Genetic Tests

- “The results of the (Molecular Pathology) procedure may require interpretation by a physician or other qualified healthcare professional. When only the interpretation and report are performed, modifier -26 may be appended to the specific molecular pathology code.”

- CMS has created a new HCPCS code for the physician (pathologist) interpretation of the new molecular pathology procedures (CPT codes 81200 – 81497)

- **G0452** Molecular pathology procedure; physician interpretation and report

- 2013 Unadjusted Medicare Payment: $18.38
Reporting the Interpretation of Genetic Tests

- G0452 is considered a “clinical laboratory interpretation service” and must:
  - Be requested by patients attending physician*
  - Result in a written narrative report included in the patient’s medical record
  - Require the exercise of medical judgment by the consulting physician

*a hospital’s standing order policy may substitute for individual request by patient’s attending physician
The Palmetto MolDx Program
Palmetto’s MolDx Program

- Based on LCD for Molecular Diagnostic Tests (MDT) (L32288) published 5/7/2012

- Currently applies to MAC J1; CA, NV, HI & Pacific Territories

- Confirms non-coverage for all molecular diagnostic tests not covered by a NCD, LCD or coverage article published by Palmetto unless submitted with Palmetto assigned identifier.

- Effective June 1, 2012, claims without required identifier will be returned as unprocessable.
(MolDx) Program: Definitions

- **MDT (Molecular Diagnostic Test):** Any test that involves the detection or identification of nucleic acid(s) (DNA/RNA), proteins, chromosomes, enzymes, cancer chemotherapy sensitivity and/or other metabolite(s). The test may or may not include multiple components. A MDT may consist of a single mutation analysis/identification, and/or may or may not rely upon an algorithm or other form of data evaluation/derivation.

- **LDT (Laboratory Developed Test):** Any test developed by a laboratory without FDA approval or clearance.
(MolDx) Program: Scope

Policy applies to:

- Molecular Diagnostic Tests (MDTs)
- All non-FDA approved/cleared laboratory developed tests (LDTs)
- All modified FDA-approved/cleared kits/tests/assays
- All tests/assays billed with more than one CPT code to identify the service, including combinations of method-based, serology-based, and anatomic pathology codes
- Tests billed with a “Not Otherwise Classified” or “Unlisted” code
(MolDx) Program Details:
Creation of Test Registry

**Required Information:**
- Laboratory name, address and contact information
- Medical Director name, address, email
- Medicare#, CLIA#, NPI# and State license#
- Test name, description, methodology, components
- CPT code(s) presently used plus applicable new MolPath codes
- Algorithm
- FDA approval
- Specimen and patient instructions
- Test kit manufacturer (if applicable)
- Sensitivity, specificity
(MolDx) Program Details: Claims Submission

- MolDx tests are submitted with CPT or HCPCS code plus Z code or Palmetto Test Identifier (PTI)
- Claims for tests defined as MolDx procedures will be returned as unprocessable if no Z code or PTI is provided
- If Z code or PTI is in process or not available, for now, Palmetto will also accept a fax and completed Test Identifier Application Form with claims.
(MolDx) Program Details: Coverage Determination

- Applies to new tests and eventually all tests with Z-Codes

- Request for coverage must include:
  - Registration information
  - Names of comparable assays/services and similarity/variance
  - Executive summary and electronic copies of publications supporting coverage
  - Clinical validity supported by at least 2 published papers (+/- predictive value, accuracy, precision, & reproducibility)
  - Clinical utility supported by at least 2 published papers (how is physician behavior influenced by test results)
  - List price, price paid by other insurers
## Palmetto MolDx Program: Covered Tier 1 MoPath Procedures

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>81201 - 81203</td>
<td>APC, full gene seq., known familial variants, dup/del. anal.</td>
</tr>
<tr>
<td>81206 - 81208</td>
<td>BCR/ABL, major/minor/other breakpoints</td>
</tr>
<tr>
<td>81210</td>
<td>BRAF, V600E variant</td>
</tr>
<tr>
<td>81215, 81217</td>
<td>BRCA1, BRCA2, known familial variants</td>
</tr>
<tr>
<td>81225 - 81227</td>
<td>CYP2C19, CYP2D6, CYP2C9, common variants</td>
</tr>
<tr>
<td>81235</td>
<td>EGFR, common variants</td>
</tr>
<tr>
<td>81240, 81241</td>
<td>F2, F5 genes</td>
</tr>
<tr>
<td>81256</td>
<td>HFE, common variants</td>
</tr>
</tbody>
</table>
Palmetto MolDx Program:
Covered Tier 1 MoPath Procedures

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>81257</td>
<td>HBA1/HBA2, common deletions or variant</td>
</tr>
<tr>
<td>81261, 81262</td>
<td>IGH@, rearrangement by PCR, direct probe</td>
</tr>
<tr>
<td>81263</td>
<td>IGH@, somatic mutation analysis</td>
</tr>
<tr>
<td>81264</td>
<td>IGK@, rearrangement analysis</td>
</tr>
<tr>
<td>81267 -81268</td>
<td>Chimerism analysis</td>
</tr>
<tr>
<td>81270</td>
<td>JAK2, pVal617Phe(V617F) variant</td>
</tr>
<tr>
<td>81275</td>
<td>KRAS, variants in condons 12 and 13</td>
</tr>
<tr>
<td>81291</td>
<td>MTHFR, common variants</td>
</tr>
</tbody>
</table>
## Palmetto MolDx Program:
### Covered Tier 1 MoPath Procedures

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>81292 - 81294</td>
<td>MLH1, full seq., known familial variants, dup./del. anal.</td>
</tr>
<tr>
<td>81295 - 81297</td>
<td>MSH2, full seq., known familial variants, dup./del. anal.</td>
</tr>
<tr>
<td>81298 - 81300</td>
<td>MSH6, full seq., known familial variants, dup./del. anal.</td>
</tr>
<tr>
<td>81301</td>
<td>Microsatellite instability</td>
</tr>
<tr>
<td>81310</td>
<td>NPM1, exon 12 variants</td>
</tr>
<tr>
<td>81315</td>
<td>PML/RARalpha translocation analysis</td>
</tr>
<tr>
<td>81217 - 81319</td>
<td>PMS2, full seq., known familial variants, dup./del. anal.</td>
</tr>
<tr>
<td>81321 - 81323</td>
<td>PTEN, full seq., known familial variants, dup./del. anal.</td>
</tr>
<tr>
<td>CPT Codes</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>81324 - 81326</td>
<td>MLH1, full seq., known familial variants, dup./del. anal.</td>
</tr>
<tr>
<td>81324 - 81326</td>
<td>PMP22, dup./del. anal., full seq., known familial variants.</td>
</tr>
<tr>
<td>81332</td>
<td>SERPINA1, common variants</td>
</tr>
<tr>
<td>81340 - 81342</td>
<td>TRB@, rearrangement anal., PCR and direct probe</td>
</tr>
<tr>
<td>81355</td>
<td>VKORC1, common variants</td>
</tr>
<tr>
<td>81315</td>
<td>PML/RARalpha translocation analysis</td>
</tr>
<tr>
<td>81217 - 81319</td>
<td>PMS2, full seq., known familial variants, dup./del. anal.</td>
</tr>
<tr>
<td>81321 - 81323</td>
<td>PTEN, full seq., known familial variants, dup./del. anal.</td>
</tr>
</tbody>
</table>
## Palmetto MolDx Program:
### Covered Tier 1 MoPath Procedures

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>81201 - 81203</td>
<td>APC, full gene seq., known fam variants, dup/del. anal.</td>
</tr>
<tr>
<td>81215, 81217</td>
<td>BRCA1, BRCA2, known fam. variants</td>
</tr>
<tr>
<td>81210</td>
<td>BRAF gene</td>
</tr>
<tr>
<td>81206 - 81208</td>
<td>BCR/ABL, major/minor/other breakpoints</td>
</tr>
<tr>
<td>81225 - 81227</td>
<td>CYP2C19, CYP2D6, CYP2C9 genes</td>
</tr>
<tr>
<td>81235</td>
<td>EGFR common variants</td>
</tr>
<tr>
<td>81240, 81241</td>
<td>F2, F5 genes</td>
</tr>
</tbody>
</table>
Draft WPS/Noridian Local Coverage Policy: Genetic Tests for Cancer

- Genetic tests for cancer are covered for:
  - Personal history of relevant cancer, even if cured
  - Test must be used to manage a patient, the results should affect at least one management option (i.e. surgery, surveillance, chemotherapy)
  - Predictive or pre-symptomatic tests in absence of past or present illness are not covered (i.e. tests based on family history of cancer)
### Draft WPS/Noridian Local Coverage Policy: Genetic Tests for Cancer

<table>
<thead>
<tr>
<th>Disease/Condition</th>
<th>Genes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hereditary Breast and Ovarian Cancer</td>
<td>BRACA1 and BRACA2</td>
</tr>
<tr>
<td>Hereditary Colorectal and Endometria Cancer syndromes Treatment with erbitus or</td>
<td>APC, KRAS, MLH1, MLH2, MSH6,</td>
</tr>
<tr>
<td>panitumumab</td>
<td>PMS2</td>
</tr>
<tr>
<td>&gt;20 cumulative lifetime colorectal adenomas</td>
<td>APC and MYH</td>
</tr>
</tbody>
</table>
Draft WPS/Noridian Local Coverage Policy: Genetic Tests for Cancer

<table>
<thead>
<tr>
<th>Disease/Condition</th>
<th>Genes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior to initiating abacavir therapy for HIV disease</td>
<td>HLA-*B57:01</td>
</tr>
<tr>
<td>Chronic myeloproliferative disease</td>
<td>JAC2, BCR/ABL fusion gene</td>
</tr>
<tr>
<td>Colorectal cancer patients treated with cetuximab or panitumumab</td>
<td>KRAS</td>
</tr>
</tbody>
</table>
How is Medicare Payment Being Set for MoPath Codes?
The Gap-Filling Process: Regulatory Basis

- (b) Gapfilling is used when no comparable existing test is available.

- (1) In the first year, carrier-specific amounts are established for the new test code using the following sources of information to determine gapfill amounts, if available:
  - (i) Charges for the test and routine discounts to charges;
  - (ii) Resources required to perform the test;
  - (iii) Payment amounts determined by other payers; and
  - (iv) Charges, payment amounts, and resources required for other tests that may be comparable or otherwise relevant.

[71 FR 69786, Dec. 1, 2006, as amended at 72 FR 66401, Nov. 27, 2007]
The Gap-Filling Process: Regulatory Basis

- (b) Gap-filling is used when no comparable existing test is available.

- (2) In the second year, the test code is paid at the national limitation amount, which is the median of the carrier-specific amounts.

- (3) For a new test for which a new or substantially revised HCPCS code was assigned on or before December 31, 2007, after the first year of gap-filling, CMS determines whether the carrier-specific amounts will pay for the test appropriately. If CMS determines that the carrier-specific amounts will not pay for the test appropriately, CMS may crosswalk the test.

[71 FR 69786, Dec. 1, 2006, as amended at 72 FR 66401, Nov. 27, 2007]
The Gap-Filling Process in Action

Effective Jan 1, 2013 each Medicare contractor was to set and pay a specific amount for each of the 105 molecular pathology gap-filled codes based on:

- Charges (and routine discounts) for each test
- Resources (cost) required to perform the test
- Payment amounts determined by other payers
- Charges, payment amounts, and resources required for other “comparable or relevant” tests
The Gap-Filling Process in Action

- What has actually happened . . .
- Only a few contractors have posted their fees
- In many cases individual fees are as much as 60% below 2012 reimbursement levels and often less than the cost to perform the test
- Many contractors have delayed all MoPath payments until the end of April, creating cash flow problems for many providers
- Pressure is building to:
  - Abandon the gap-fill process
  - Come up with rational payment amounts
The Gap-Filling Process in Action

- **What comes next . . .**

- By April 30th, CMS must post interim contractor-specific amounts on the CMS website.

- A 60-day comment period follows (during May and June of 2013).

- After considering the public comments, CMS will post final contractor-specific amounts and NLAs on the CMS website (probably by mid-August of 2013).

- The National Limitation Amount (NLA) for each CPT code will be set at the median of the final contractor-specific amounts.
The Gap-Filling Process in Action

- **Reconsideration** . . .

  - CMS will accept reconsideration requests for 30 days after final contractor amounts and NLAs are posted (probably during September).

  - As the result of a reconsideration, CMS may revise the national limitation amount for the new test. (usually published mid-November as part of final Laboratory Fee Schedule rule)

  - If CMS revises the amount of payment as the result of a reconsideration, the new amount of payment is final and is not subject to further reconsideration.

  - If CMS changes a determination as the result of a reconsideration, the new payment is effective January 1, 2014.
## Palmetto GBA: Initial Contractor Payments

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Commercial Payers Avg Reimb. (Xfin data)</th>
<th>2012 Medicare Median Reimb. (Lab Econ data)</th>
<th>Palmetto Gapfill $</th>
<th>Cahaba Gapfill $</th>
</tr>
</thead>
<tbody>
<tr>
<td>81206 BCR/ABL 1, Major Breakpoint</td>
<td>$214.33</td>
<td>$121.00</td>
<td>$108.00</td>
<td>$123.00</td>
</tr>
<tr>
<td>81210 BRAF, V600E variant</td>
<td>$427.00</td>
<td>$84.00</td>
<td>$58.00</td>
<td>$123.00</td>
</tr>
<tr>
<td>81225 CYP2C19, variants</td>
<td>$236.00</td>
<td>$379</td>
<td>$135.00</td>
<td>$305.00</td>
</tr>
<tr>
<td>81226 CYP2D6, variants</td>
<td>$426.00</td>
<td>$563</td>
<td>$148.00</td>
<td>$50.00</td>
</tr>
<tr>
<td>81227 CYP2C9, variants</td>
<td>$238.00</td>
<td>$344</td>
<td>$97.00</td>
<td>$50.00</td>
</tr>
<tr>
<td>81235 EGFR variants</td>
<td>$1545.00</td>
<td>$524</td>
<td>$116.00</td>
<td>$123.00</td>
</tr>
</tbody>
</table>
## Cahaba & Palmetto Tier 2 Gapfill Amounts

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Cahaba Payments</th>
<th>Palmetto Average Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>81400 Tier Two, Level 1</td>
<td>$123.00</td>
<td>$64.61</td>
</tr>
<tr>
<td>81401 Tier Two, Level 2</td>
<td>$140.00</td>
<td>$106.18</td>
</tr>
<tr>
<td>81402 Tier Two, Level 3</td>
<td>$205.00</td>
<td>$115.75</td>
</tr>
<tr>
<td>81403 Tier Two, Level 4</td>
<td>$235.00</td>
<td>none</td>
</tr>
<tr>
<td>81404 Tier Two, Level 5</td>
<td>$305.00</td>
<td>$206.96</td>
</tr>
<tr>
<td>81405 Tier Two, Level 6</td>
<td>$450.00</td>
<td>none</td>
</tr>
<tr>
<td>81406 Tier Two, Level 7</td>
<td>$650.00</td>
<td>$337.74</td>
</tr>
<tr>
<td>81407 Tier Two, Level 8</td>
<td>$1,200.00</td>
<td>none</td>
</tr>
<tr>
<td>81408 Tier Two, Level 9</td>
<td>$2,900.00</td>
<td>none</td>
</tr>
</tbody>
</table>
Other Palmetto Payment Issues

- Palmetto has stated that they consider pathology procedures such as microdissection (88380, 88381) or macroscopic tissue preparation prior to analysis (88387, 88388) to be part of the Molecular Pathology procedure.

- CPT states that “Any procedure required prior to cell lysis (e.g. microdissection codes 88380 and 88381) should be reported separately.”
Category I MAAA Codes

- Must be FDA approved (if required)
- Must be in widespread use (ordered by many physicians, performed in many laboratories)
- Must be clinically valid (widely used for diagnosis/treatment of patients)
Administrative MAAA’s

- A separate list of MAAA codes provides an administrative coding system to acknowledge and report MAAA services.
- Inclusion does not indicate that the test’s clinical utility has been assessed, verified or endorsed by the American Medical Association.
- The minimum standard for inclusion in this list is that an analysis for patient care is commercially available.
- New Administrative MAAA’s will be published after each CPT editorial Panel Meeting.
MAAA Coding Rules

• When a specific MAAA procedure is not listed in either the Administrative or Category I MAAA section, report the analysis using the Category I MAAA unlisted code (81299).

• When an analysis is performed that may potentially fall within a specific descriptor, however the proprietary name is not included in table below, 81299 should be used.

• MAAA’s may not be reported using MoPath or other codes for their component tests, EXCEPT FOR MEDICARE CLAIMS.
Medicare Coding and Payment for MAAA’s

- CMS does not recognize MAAA codes but will continue to pay for the component tests required to obtain the algorithm based result.

- In other words, they do not recognize the algorithm as a payable service (It is considered a calculation).

- However, this creates problems for Molecular Pathology based MAAAs because the component genes analyzed may only be reportable the unlisted MoPath CPT code 81479 for which no payment is typically made without detailed development.
How to Comment/Complain

- Comments regarding payment amounts should include specific reason(s) why the payment is “inappropriate”

- Fee is less than cost to perform the test
  - show detailed cost analysis – be accurate!

- Different payment amounts are/have been determined (paid) by other payers
  - Show previous Medicare payments
  - Show payments by commercial payers
Contact Information:

- Charles Root, Ph.D.
- CodeMap LLC
- 1901 Roselle Road, Suite 640
- Schaumburg, IL 60195
- charlesroot@codemap.com
- 837-381-5465 Ext 1