Unique Test Identifiers for Non-Specific Procedure Codes

MOL.CS.107.A

Procedure(s) addressed by this policy:	Procedure Code(s)
MOPATH PROCEDURE LEVEL 1	81400
MOPATH PROCEDURE LEVEL 2	81401
MOPATH PROCEDURE LEVEL 3	81402
MOPATH PROCEDURE LEVEL 4	81403
MOPATH PROCEDURE LEVEL 5	81404
MOPATH PROCEDURE LEVEL 6	81405
MOPATH PROCEDURE LEVEL 7	81406
MOPATH PROCEDURE LEVEL 8	81407
MOPATH PROCEDURE LEVEL 9	81408
UNLISTED MOLECULAR PATHOLOGY	81479
UNLISTED MAAA	81599
CLINICAL CHEMISTRY TEST	84999

Description

This policy provides instruction on how to submit a unique test identifier when a procedure code is billed that does not adequately describe the performed molecular or genomic test referred to here as “non-specific procedure codes.”

Given the large and rapidly increasing number of molecular and genomic tests, many tests do not have unique procedure codes and are instead billed with non-specific procedure codes. These non-specific procedure codes generally fall into one of the following categories.

Tier 2 Codes

Tier 2 Molecular Pathology codes (81400-81408) are a set of CPT codes designed to represent the level of technical and interpretive effort required for a large number of molecular and genomic tests that have not been assigned a unique CPT code (i.e., are not addressed by Tier 1, GSP, MAAA, etc. codes). Specific tests, or analytes, are assigned to these Tier 2 codes by the AMA a few times yearly and cannot be self-assigned by the laboratory.

The AMA has published a set of gene abbreviations or analyte identifiers, called claim designation codes, for each test assigned to a tier 2 code. These codes are intended to provide billing transparency such that the combination of a tier 2 code and the

applicable claim designation code on a claim form are reasonably specific to the test performed.

Unlisted Codes

If a molecular or genomic test has not been assigned to any test-specific or Tier 2 CPT code, those tests are generally billed under one of the following unlisted codes:

- 81479: Unlisted molecular pathology procedure
- 81599: Unlisted multianalyte assay with algorithmic analysis
- 84999: Unlisted chemistry procedure

The proper unlisted code depends on the nature of the test, but most molecular tests are best described by 81479 or 81599.

There is no publicly-available, widely-adopted source of unique codes for tests billed under unlisted codes.

The Palmetto MolDX program requires that most molecular tests be registered with the program and obtain a unique identifier (McKesson Z-Code or Palmetto Test Indicator) for the purposes of claim processing. However, this identifier is both lab and test-specific and is currently primarily utilized by only certain Medicare jurisdictions.

Criteria

Unique Test Identifier Development

Tier 2 AMA Claim Designation Codes

For tests billed under a Tier 2 CPT code, the unique test identifier will be the same as the claim designation code published by the AMA, provided the claim designation code describes only a single test assigned to that Tier 2 code. In the event that the same claim designation code could describe more than one test assigned to the same Tier 2 code, eviCore will assign a unique code (not the original AMA claim designation code) to at least one of these tests.

Tier 2 Special Cases

Tier 2 code 81403 allows for known familial variant testing to be billed without specific assignment if the gene that harbors the known familial variant has been listed under any other Tier 1 or Tier 2 code description. The unique test identifier for known familial variants not otherwise specified are generally the AMA assigned claim designation code with the addition of “KFM” (e.g., FGFR3 and FGFR3KFM).

Unlisted Codes

For tests billed under unlisted procedure codes, a unique code will be developed unrelated to the Tier 2 claim designation codes. No separate registration or notification process is required on the part of the laboratory.

400 Buckwalter Place Boulevard, Bluffton, SC 29910 (800) 918-8924

Obtaining A Unique Test Identifier

When a medical necessity review is performed for a test that will be billed under a non-specific procedure code, billing instructions including the appropriate unique test identifier will be provided in the determination communication.

If a medical necessity review is not performed for a test that will be billed under a non-specific procedure code, a unique test identifier can be obtained by contacting eviCore through the phone number provided by the health plan or on the eviCore website, at www.evicore.com, under Lab Management Tools and Resources. However, most non-specific procedure codes require medical necessity determination. If pre-service medical necessity determination is required and not obtained, that requirement will take precedence over any other billing requirements. A voluntary medical necessity determination request may also be submitted for any non-specific procedure code regardless of the plan's requirements.

Billing Tests Using Non-specific Procedure Codes

All tests billed with a non-specific procedure code as defined in the table at the top of this policy must include a unique test identifier on the claim regardless of medical necessity review requirements or determination outcome.

Enter the unique test identifier in one of the following narrative fields based on the type of claim being submitted:

Claim Type	Electronic Claim	Paper Claim
Professional	837P: Enter in the 2400 SV101-7 field (Line Item Description) associated with the non-specific CPT code. Each non-specific CPT code should have a unique identifier in the associated field.	CMS-1500: Enter in box 24 in the shaded line above the service line that contains the non-specific CPT code. Each non-specific CPT code should have a unique identifier entered above it. Each test identifier should have the qualifier "ZZ" appended at the beginning (e.g., ZZBRAF).
Institutional	837I: Enter in the 2400 SV202-7 field (Line Item Description) associated with the non-specific CPT code. Each non-specific CPT code should have a unique identifier in the associated field.	UB-04: Enter in box 80 (Remarks). Only a single non-specific CPT code should be billed per claim form due to the limitations of a single descriptive field. The test identifier should have the qualifier "ZZ" appended at the beginning (e.g., ZZBRAF).

References

1. American Medical Association. Molecular Pathology Codes and Background Information. Available at: https://download.ama-assn.org/resources/doc/cpt/x-pub/mopath-codes-and-background-information.pdf.
2. American Medical Association. MoPath Gene Designation Chart. Available at: www.ama-assn.org/resources/doc/cpt/x-pub/mopath-gene-designation-chart.pdf.
3. Palmetto GBA. MolDX Program Information. Available at: http://www.palmettogba.com/palmetto/MolDX.nsf/DocsCatHome/MolDx.
4. American Medical Association. CPT CodeBridge. Available at: http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/cpt-codebridge.page

400 Buckwalter Place Boulevard, Bluffton, SC 29910 (800) 918-8924