



News Flash – The Centers for Medicare & Medicaid Services (CMS) is listening and wants to hear from you about the services provided by your Medicare Fee-for-Service (FFS) contractor that processes and pays your Medicare claims. CMS is preparing to conduct the fifth annual Medicare Contractor Provider Satisfaction Survey (MCPSS). This survey offers Medicare FFS providers and suppliers an opportunity to give CMS feedback on their interactions with Medicare FFS contractors related to seven key business functions: Provider Inquiries, Provider Outreach & Education, Claims Processing, Appeals, Provider Enrollment, Medical Review, and Provider Audit & Reimbursement. The survey will be sent to a random sample of approximately 30,000 Medicare FFS providers and suppliers. Those who are selected to participate in the 2010 MCPSS will be notified starting in January. If you are selected to participate, please take a few minutes to complete this important survey. Providers and suppliers can complete the survey on the Internet via a secure website or by mail, fax, or telephone. To learn more about the MCPSS, please visit <http://www.cms.gov/MCPSS> on the CMS website.

MLN Matters® Number: MM6557

Related Change Request (CR) #: 6557

Related CR Release Date: December 18, 2009

Effective Date: January 1, 2010

Related CR Transmittal #: R1876CP and R117BP

Implementation Date: April 5, 2010

Coverage of Kidney Disease Patient Education Services

Provider Types Affected

This article affects physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for Kidney Disease Education services provided to Medicare beneficiaries diagnosed with Stage IV chronic kidney disease (CKD).

Provider Action Needed



STOP – Impact to You

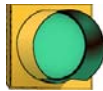
This article is based on Change Request (CR) 6557 which implements Kidney Disease Education (KDE) Services as a Medicare Part B covered benefit for Medicare beneficiaries diagnosed with Stage IV CKD.

Disclaimer

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**CAUTION – What You Need to Know**

KDE services are designed to provide beneficiaries with comprehensive information regarding the management of comorbidities, including for purposes of delaying the need for dialysis; prevention of uremic complications; and each option for renal replacement therapy. This benefit is also designed to be tailored to individual needs and provide the beneficiary with the opportunity to actively participate in his/her choice of therapy. The Centers for Medicare & Medicaid Services (CMS) issued two new Healthcare Common Procedure Coding System (HCPCS) codes to be used to report covered KDE services: **G0420** (Face-to-face educational services related to the care of chronic kidney disease; individual, per session; per one hour) and **G0421** (Face-to-face educational services related to the care of chronic kidney disease; group, per session, per one hour).

**GO – What You Need to Do**

See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

By definition, CKD is kidney damage for 3 months or longer, regardless of the cause of kidney damage. CKD typically evolves over a long period of time and patients may not have symptoms until significant, possibly irreversible, damage has been done. Complications can develop from kidneys that do not function properly, such as high blood pressure, anemia, and weak bones. When chronic kidney disease progresses, it may lead to kidney failure, which requires artificial means to perform kidney functions (dialysis) or a kidney transplant to maintain life.

Individuals with CKD may benefit from KDE interventions due to the large amount of medical information that could affect patient outcomes, including the increasing emphasis on self-care and patients' desire for informed, autonomous decision-making. Pre-dialysis education can help patients achieve better understanding of their illness, dialysis modality options, and may help delay the need for dialysis. Education interventions should be patient-centered, encourage collaboration, offer support to the patient, and be delivered consistently.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA Section 152(b)) added KDE services as a Medicare Part B covered benefit for Medicare beneficiaries diagnosed with Stage IV CKD who have received a referral from the physician managing the beneficiary's kidney condition.

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KDE Content Requirements

CMS published regulations implementing this provision at 42 CFR 410.48. Medicare Part B covers KDE services, provided by a qualified person, who provides comprehensive information regarding the management of comorbidities, including for the purpose of delaying the need for dialysis; the prevention of uremic complications; therapeutic options, treatment modalities, and settings, including a discussion of the advantages and disadvantages of each treatment option, and how the treatments replace the kidney; opportunities for beneficiaries to actively participate in the choice of therapy; and be tailored to meet the needs of the individual beneficiary involved.

KDE Outcomes Assessments

Qualified persons that provide KDE services will develop outcomes assessments that are designed to measure beneficiary knowledge about CKD and its treatment. It also serves to assist KDE educators and CMS in improving subsequent KDE programs and patient understanding and assessing program effectiveness. The assessment will be administered to the beneficiary during a KDE session, and will be made available to CMS upon request.

KDE Billing Instructions

Change Request (CR) 6557 instructs Medicare contractors to pay for KDE services that meet the following conditions:

- No more than 6 sessions of KDE services are provided in a beneficiary's lifetime;
- Sessions billed in increments of one hour (if the session is less than 1 hour, it must last at least 31 minutes in order to be billed, in which case a session less than one hour and longer than 31 minutes is billable as one session);
- Sessions furnished either individually or in a group setting of 2 to 20 individuals (who need not all be Medicare beneficiaries); and
- Furnished, upon the referral of the physician managing the beneficiary's kidney condition, by a qualified person meaning a:
 - Physician, physician's assistant, nurse practitioner, or clinical nurse specialist;
 - Hospital, critical access hospital (CAH), skilled nursing facility (SNF); comprehensive outpatient rehabilitation facility (CORF), home health agency (HHA), or hospice, that is located in a rural area; or
 - Hospital or CAH that is paid as if it were located in a rural area (hospitals and CAHs reclassified as rural under section 42 CFR 412.103).

The following providers are not 'qualified persons' and are excluded from furnishing KDE services:

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- A hospital, SNF, CORF, HHA, or hospice located outside of a rural area (using the Actual Geographic Location Core Based Statistical Area (CBSA) to identify facilities located outside of a rural area under the Medicare Physician Fee Schedule (MPFS)), unless the services are furnished by a hospital or CAH that is treated as being in a rural area (such claims are denied with Claims Adjustment Reason Code (CARC) 170 (Payment is denied when performed/billed by this type of provider)) and Medicare Summary Notice (MSN) 21.6 (This item or service is not covered when performed, referred, or ordered by this provider.); and
- Renal dialysis facilities (Type of Bill (TOB) 72x).

CMS issued two new HCPCS codes G0420 and G0421 to be used to report covered KDE services in the January 2010 Integrated Outpatient Code Editor (IOCE) and MPFS Database) and identified the payment amounts in the final 2010 MPFS. One of these HCPCS codes must be present, along with ICD-9-CM code 585.4 (chronic kidney disease, Stage IV (severe)), in order for a claim to be processed and paid correctly.

Medicare contractors will deny claims for KDE services billed without ICD-9-CM code 585.4 using CARC 167 (This (these) diagnosis(es) is(are) not covered.)

Medicare contractors will deny claims with HCPCS G0420 or G0421 and ICD-9-CM 585.4 for more than 6 sessions using claims adjustment reason code (CARC) 119 (Benefit maximum for this time period or occurrence has been reached).

Medicare will not pay a professional claim and an institutional claim for HCPCS G0420 or G0421 and ICD-9-CM 585.4 where both claims contain the same date of service. If such claims are received, the initial claim is paid and subsequent claims are denied using CARC 18 (Duplicate claim/service).

NOTE: If a signed ABN was provided, Medicare contractors will use Group Code PR (patient responsibility), and the liability falls to the beneficiary. If an ABN was not provided, contractors use Group Code CO (contractual obligation) and the liability falls to the provider.

The following additional billing requirements are applicable to KDE claims submitted by institutional providers to MACs or FIs:

- MACs/FIs will reimburse for KDE Services when rendered in a rural area and submitted on the following TOBs: 12X, 13X, 22X, 23X, 34X, 75X, 81X, and 82X. NOTE: TOB 85X is reimbursable for KDE Services regardless of the provider's geographical location;

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- MACs/FIs will use the Actual Geographic Location CBSA to identify facilities located in rural areas under the MPFS.
- KDE Services are covered when claims containing the above-mentioned TOBs are received from section 401 hospitals (the provider is found on the annually updated Table 9C of the Inpatient Prospective Payment System final rule);
- Revenue code 0942 (Other therapeutic services; education/training) should be reported when billing for KDE Services on TOBs 22X, 23X, 34X, 75X, 81X, 82X, and 85X;
- Medicare will return to provider hospice claims, TOBs 81X and 82X, billing for KDE services with revenue code 0942 when any other services are also included;
- Hospices must include value code 61 or G8 when billing for G0420 or G0421; and,
- Hospital outpatient departments should bill for KDE Services under any valid/appropriate revenue code, and they are not required to report revenue code 0942. Maryland hospitals under jurisdiction of the Health Services Cost Review Commission, TOBs 12X and 13X, are paid on an inpatient Part B basis in accordance with the terms of the Maryland Waiver.

Additional Information

Be aware that Medicare contractors will not search their files for claims with service dates on or after January 1, 2010, that are processed prior to the implementation of CR6557. However, if you identify such claims to your Medicare contractor, they will adjust them. The official instruction, CR 6557, was issued via two transmittals, one revising the Medicare Claims Processing Manual, Chapter 32, Section 20, and one for revisions to the Medicare Benefit Policy Manual, Chapter 15, Section 310. These transmittals are available at <http://www.cms.gov/Transmittals/downloads/R1876CP.pdf> and <http://www.cms.gov/Transmittals/downloads/R117BP.pdf>, respectively, on the CMS website. If you have questions, please contact your carrier, FI, A/B MAC, or RHHI at their toll-free numbers, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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