CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1849	**Date: May 12, 2017**
	Change Request 9989

SUBJECT: Implementation of Modifier CG for Type of Bill 72x

I. SUMMARY OF CHANGES: This Change Request (CR) implements modifier CG which will identify non-medically justified dialysis treatments.

EFFECTIVE DATE: October 1, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 2, 2017

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
N/A	N/A

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:

One Time Notification

Attachment - One-Time Notification

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I. GENERAL INFORMATION

A. Background: When the End Stage Renal Disease (ESRD) Prospective Payment System (PPS) was implemented in 2011, the Centers for Medicare & Medicaid Services (CMS) adopted a per treatment unit of payment. This per treatment unit of payment is the same base rate that is paid for all dialysis treatment modalities furnished by an ESRD facility hemodialysis (HD) and the various forms of peritoneal dialysis (PD). Consistent with CMS policy since the composite rate payment system was implemented in the 1980s, CMS also adopted the 3-times weekly payment limit for HD under the ESRD PPS. When a beneficiary's plan of care requires more than three weekly dialysis treatments, whether HD or daily PD, we apply payment edits to ensure that Medicare payment on the monthly claim is consistent with the 3-times weekly dialysis treatment payment limit. Thus, for a 30-day month, payment is limited to 13 treatments, and for a 31-day month payment is limited to 14 treatments, with exceptions made for medical justification.

B. Policy: Modifer CG

In order to accurately capture all treatments provided to a beneficiary, CMS is implementing a new modifier CG – Policy Criteria Applied for the 72x type of bill (TOB) when used in the billing of hemodialysis treatments for patients with ESRD in excess of the 13 or 14 monthly allowable treatments. This applies to Revenue Codes 0821 and 0881. This policy is applicable for all condition codes.

Modifier CG – Policy Criteria Applied is used to identify dialysis treatments (CPT 90999) in excess of 13 or 14 per month that do not meet medical justification requirements as defined by the Medicare Administrative Contractors. This modifier shall be appended to the claim line for the date of service associated with the excess treatment. This modifier indicates that the facility attests the additional treatment does not meet medical justification requirements and should not be paid separately.

The contractors should continue to use existing processes to determine medical justification for claim lines in excess of 13/14 per month that do not include the new modifier. When a claim line includes modifier CG – Policy Criteria Applied and medical justification, the claim line should not be separately payable, regardless of whether the monthly treatment limit has been reached.

In the Calendar Year 2017 ESRD PPS Final Rule (81 FR 77848) we reiterated that we pay the full ESRD PPS base rate for all training treatments (condition code 73 or 87) even when they exceed 3 times per week with a limit of 25 sessions.

If medical justification is present without modifier CG, the claim line should pay separately.

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	
9989.1	Medicare Contractors shall accept new modifier CG: Policy Criteria Applies on TOB 72x.	X								
9989.2	Medicare Contractors shall not pay service lines on ESRD claims: • TOB 72x • Revenue codes 0821 or 0881. • HCPCS code 90999 with modifier CG. Payment should not be made for these services even when the claim contains the medical justification diagnosis code. NOTE: This does ***not*** apply to training treatments (condition code 73 or 87). These services should be paid when modifier CG is present and they are within the current limitations.	X				X				
9989.3	Medicare Contractors shall ensure ESRD claims, TOB 72x, with revenue code 0821 or 0881, HCPCS code 90999 and modifier CG are not included in the monthly 13/14 dialysis session frequency count on the ESRD Parameter screen.					X				
9989.4	Medicare Contractors shall create a line level reason code to assign on service lines for TOB 72X with: • Revenue codes 0821 or 0881 • HCPCS code 90999 • Modifier CG **NOTE:** The edit should be bypassed for training treatments (condition code 73 or 87).					X				
9989.5	Medicare Contractors shall deny service lines on TOB 72X with:	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• Revenue codes 0821 or 0881 • HCPCS code 90999 • Modifier CG									
9989.5.1	Medicare Contractors shall use the following ANSI information: • Group code: CO • CARC 96 - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. MSN 16.34 - You should not be billed for this service. You are only responsible for any deductible and coinsurance amounts listed in the 'You May Be Billed' column.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9989.6	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the	X				

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.					

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Janae James, 410-786-0801 or janae.james@cms.hhs.gov , Michelle Cruse, 410-786-7540 or michelle.cruse@cms.hhs.gov

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

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0