CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 840	**Date: January 21, 2011**
	Change Request 7284

SUBJECT: Revision of the ICD-9 CM Codes Recognized for a Co-morbidity Payment Adjustment under the End Stage Renal Disease Prospective Payment System

I. SUMMARY OF CHANGES: Diagnosis codes 484.6 and 484.7 are two diagnoses that are not eligible for a co-morbidity payment adjustment under the ESRD PPS. Therefore, 484.6 and 484.7 are being removed from the bacterial pneumonia co-morbidity category to prevent incorrect payment on ESRD PPS claims effective January 1, 2011.

EFFECTIVE DATE: January 1, 2011
IMPLEMENTATION DATE: July 5, 2011

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	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

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

**Unless otherwise specified, the effective date is the date of service.*

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 840	Date: January 21, 2011	Change Request: 7284

SUBJECT: Revision of the ICD-9 CM Codes Recognized for a Co-morbidity Payment Adjustment under the End Stage Renal Disease Prospective Payment System

Effective Date: January 1, 2011

Implementation Date: July 5, 2011

I. GENERAL INFORMATION

A. Background: Transmittal 2094, Change Request (CR) 7064 entitled "End Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Consolidated Billing for Limited Part B Services" implemented a new bundled payment system for renal dialysis items and services provided on and after January 1, 2011. The ESRD PPS provides payment adjustments for 6 categories (3 acute and 3 chronic) of co-morbid conditions. Bacterial pneumonia is an acute co-morbidity category that is recognized as being eligible for a payment adjustment. In the August 20, 2010 release of CR 7064 in Attachment 8: Co-morbidity Categories and Diagnosis Codes, the bacterial pneumonia category included two diagnosis codes (484.6 and 484.7) that should not have been listed as eligible for the co-morbidity payment adjustment.

B. Policy: Diagnosis codes 484.6 and 484.7 are two diagnoses that are not eligible for a co-morbidity payment adjustment under the ESRD PPS. Therefore, 484.6 and 484.7 should be removed from the bacterial pneumonia co-morbidity category to prevent incorrect payment on ESRD PPS claims effective January 1, 2011. The volume of claims reporting these codes is expected to be minimal therefore contractors are not required to identify and adjust any claims with these codes. ESRD facilities that identify claims receiving adjustments for these diagnoses should adjust their claims within the timely filing period.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7284.1	Medicare systems shall not assign the payer only condition code MB for diagnosis codes 484.6 and 484.7 for ESRD claims with dates of service on or after January 1, 2011.						X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7284.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/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 site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your 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.	X		X							

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Policy: Terri.Deutsch@cms.hhs.gov or (410) 786-9462.
Claims: Wendy.Tucker@cms.hhs.gov or (410) 786-3004

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs),* include the following statement:

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.