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MLN Matters Number: MM5545

Related Change Request (CR) #: 5545

Related CR Release Date: July 13, 2007

Effective Date: January 1, 2008

Related CR Transmittal #: R1285CP

Implementation Date: January 7, 2008

Note: This article was updated on August 27, 2012, to reflect current Web addresses. All other information remains the same.

Line Item Billing Requirement for Epoetin Alfa (EPO) Submitted on End Stage Renal Disease (ESRD) Claims

Provider Types Affected

Renal Dialysis Facilities (RDFs) submitting claims to Medicare Fiscal Intermediaries (FIs) and Part A/B Medicare Administrative Contractors (A/B MACs) for EPO provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 5545, which completes the implementation of ESRD line item billing for Renal Dialysis Facilities (RDFs) by providing instructions required to submit line item billing for EPO on ESRD claims with dates of service on or after January 1, 2008. Be sure your billing staff is aware of these requirements.

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Background

The first stage of the ESRD line item billing requirement was implemented by Change Request (CR) 5039 beginning on April 1, 2007. Now, CR5545 completes the implementation of ESRD line item billing by providing instructions required to submit line item billing for EPO on ESRD claims with dates of service on or after January 1, 2008.

You can find an MLN Matters article related to CR5039 at <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM5039.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

Line item billing allows for EPO to be billed the same way as all other separately payable drugs. For claims with dates of service on or after January 1, 2008, RDFs will bill for each administration of EPO on a separate line of the 72X type of bill indicating the line item date of service for the administration. The units reported on the claim line for EPO are multiplied by the total units defined by the Healthcare Common Procedure Coding System (HCPCS) to reflect the dosage per administration. Medicare will then calculate the EPO payment based on the units reported on the line for 72X claims with dates of service on or after January 1, 2008.

RDFs are no longer required to report value code 68 with the total monthly dosage with dates of service on or after January 1, 2008.

The total number of administrations of EPO will be determined by the total number of lines on the claim billing for EPO.

When RDFs report the GS modifier, it is not required to be reported on every EPO line item. The GS modifier should be reported on the line item(s) that represent an administration of EPO at the reduced dosage following existing instructions in the *Medicare Claims Processing Manual* (Chapter 8, Section 60.4; <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c08.pdf>). No payment reduction is made when the GS modifier is present on the claim.

Supplies of EPO and Aranesp for self-administration should be billed according to the pre-determined schedule in the plan-of-care provided to the beneficiary. RDFs should submit a separate line item for each date an administration is expected to be performed with the expected dosage. In the event that the schedule was changed, the provider should note the changes in the medical record and bill according to the revised schedule. For patients beginning to self administer EPO or Aranesp at home who are receiving an extra month supply of the drug, RDFs should:

- Bill the one month reserve supply on one claim line and

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- Include the EM modifier - Emergency Reserve Supply (for ESRD benefit only).

Note that Medicare will return claims to the provider containing more than one EPO or Aranesp line with the EM modifier for claims with dates of service on or after January 1, 2008.

RDFs should include condition code 70 on claims billing for home dialysis patients that self-administer anemia management drugs, including EPO and Aranesp.

Note that the electronic form required for billing ESRD claims is the ANSI X12 837 Institutional claim transaction. The data structure of that transaction is difficult to express in narrative form. In addition, small providers who are excepted from the requirement to submit electronic claims, CMS provides instructions in CR5545 relative to the UB-04 (form CMS-1450) hardcopy form. Those instructions are in the form of a revision to the *Medicare Claims Processing Manual* and that revision is attached to CR5545.

Additional Information

The official instruction, CR5545, issued to your Medicare FI and A/B MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1285CP.pdf> on the CMS website.

If you have any questions, please contact your Medicare FI or A/B MAC at their toll-free number, which may be found on the CMS website at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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