Medicare Learning Network
MLN Matters®
CMS
Information for Medicare Fee-For-Service Health Care Professionals

News Flash – Beginning Jan 1, 2012, suppliers furnishing the technical component of advanced diagnostic imaging services for which payment is made under the physician fee schedule must be accredited by a CMS-designated accreditation organization. In the case where a physician chooses to contract out those services to an accredited mobile unit, the physician must be accredited in order to bill Medicare for such services. For more information regarding advanced diagnostic imaging, please visit http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html on the Centers for Medicare & Medicaid Services (CMS) website.

MLN Matters® Number: MM7003 Revised
Related Change Request (CR) #: 7003
Related CR Release Date: July 9, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R1999CP
Implementation Date: January 3, 2011

Note: This article was updated on December 6, 2012, to reflect current Web addresses. This article was previously revised on August 29, 2011, to add a reference to MLN Matters® article MM7520, which is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7520.pdf, to alert providers that a qualified non-physician practitioner may furnish the required monthly face-to-face visit and that the MCP physician or practitioner may use other Medicare certified physicians or qualified non-physician practitioners to provide some of the visits. MM7520 gives further details on this policy. All other information remains the same.

End Stage Renal Disease (ESRD) Home Dialysis Monthly Capitation Payment (MCP)

Provider Types Affected

This article is for physicians and providers submitting claims to Medicare contractors (carriers and/or A/B Medicare Administrative Contractors (A/B MACs)) for home dialysis MCP services provided to Medicare ESRD beneficiaries.

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 7003 which instructs that, effective January 1, 2011, the monthly capitation payment (MCP) physician (or practitioner) must furnish at least one face-to-face patient visit per month for the home dialysis MCP service as described by Current Procedure Terminology (CPT) codes 90963, 90964, 90965, and 90966.

CAUTION – What You Need to Know

Physicians and practitioners managing Medicare beneficiaries with ESRD who dialyze at home are paid a single monthly rate based on the age of the beneficiary, and currently, the Centers for Medicare & Medicaid Services (CMS) does not require a frequency of required visits for the home dialysis monthly capitation payment (MCP) service. CR 7003 instructs that, effective January 1, 2011, the MCP physician (or practitioner) must furnish at least one face-to-face patient visit per month for the home dialysis MCP service. In addition, documentation by the MCP physician (or practitioner) should support at least one face-to-face encounter per month with the home dialysis patient. However, Medicare contractors may waive the requirement for a monthly face-to-face visit for the home dialysis MCP service on a case by case basis; for example, when the nephrologist's notes indicate that the physician actively and adequately managed the care of the home dialysis patient throughout the month. The management of home dialysis patients who remain a home dialysis patient the entire month should be coded using the ESRD-related services for home dialysis patients Healthcare Common Procedure Coding System (HCPCS) codes.

GO – What You Need to Do

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

Background

In the Calendar Year (CY) 2004 physician fee schedule (PFS) final rule (68 FR 63216, November 7, 2003; see http://edocket.access.gpo.gov/2003/pdf/03-27639.pdf on the Internet), the CMS established new HCPCS G codes for end stage renal disease (ESRD) monthly capitation payments (MCPs).

For center based patients, payment for the G codes varied based on the age of the beneficiary and the number of face-to-face visits furnished each month (e.g. 1 visit, 2-3 visits and 4 or more visits). Under this methodology, the lowest payment

amount applies when a physician provides one visit per month; a higher payment is provided for two to three visits per month. To receive the highest payment amount, a physician would have to provide at least four ESRD related visits per month. However, payment for the home dialysis MCP only varied by the age of beneficiary. CMS stated that they "will not specify the frequency of required visits at this time but expect physicians to provide clinically appropriate care to manage the home dialysis patient."

Effective January 1, 2009, the American Medical Association's (AMA's) Current Procedural Terminology (CPT) Editorial Panel created CPT codes to replace the HCPCS G codes for monthly ESRD-related services, and CMS accepted these new codes. The clinical vignettes used for the valuation of the home dialysis MCP services (as described by CPT codes 90963 through 90966) include scheduled (and unscheduled) examinations of the ESRD patient.

CR 7003 instructs that, effective January 1, 2011, the MCP physician (or practitioner) must furnish at least one face-to-face patient visit per month for the home dialysis MCP service as described by CPT codes 90963, 90964, 90965, and 90966 shown in the following table. Documentation by the MCP physician (or practitioner) should support at least one face-to-face encounter per month with the home dialysis patient. However, Medicare contractors may waive the requirement for a monthly face-to-face visit for the home dialysis MCP service on a case by case basis; for example, when the nephrologist's notes indicate that the physician actively and adequately managed the care of the home dialysis patient throughout the month.

CPT Code	Descriptor
90963	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90964	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90965	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90966	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older

Additional Information

The official instruction, CR 7003, issued to your carrier and A/B MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1999CP.pdf on the CMS website.

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