

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Medicare & Medicaid Services



**News Flash** – The Version 5010 compliance date – January 1, 2012 – is fast approaching. Are you prepared for the transition? Medicare Fee-for-Service (FFS) trading partners are encouraged to contact their Medicare Administrative Contractors (MACs) now and facilitate testing to gain a better understanding of MAC testing protocols and the transition to Version 5010. To assist in this effort, the Centers for Medicare & Medicaid Services (CMS), in conjunction with the Medicare FFS Program, announce a National 5010 Testing Week to be held August 22 through August 26, 2011. National 5010 Testing Week is an opportunity for trading partners to come together and test compliance efforts that are already underway with the added benefit of real-time help desk support and direct and immediate access to MACs. For more information on Version 5010, please visit the CMS dedicated 5010 website at <http://www.CMS.gov/Versions5010andD0> on the CMS website.

MLN Matters® Number: MM7520

Related Change Request (CR) #: CR 7520

Related CR Release Date: August 5, 2011

Effective Date: January 1, 2011

Related CR Transmittal #: R2269CP

Implementation Date: November 7, 2011

## Clarification of Payment for ESRD-Related Services Under the Monthly Capitation Payment

### 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 services provided to Medicare ESRD beneficiaries.

### Provider Action Needed



#### STOP – Impact to You

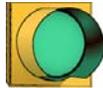
This article is based on Change Request (CR) 7520 which clarifies payment for end stage renal disease (ESRD) services under the monthly capitation payment (MCP).

#### Disclaimer

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**CAUTION – What You Need to Know**

CR 7520 instructs Medicare contractors to make payment for the home dialysis MCP service (codes 90951 – 90966), even when a qualified nonphysician practitioner furnishes the required monthly face-to-face visit(s), as described by the Medicare Claims Processing Manual, Chapter 8, Section 140 (included as an attachment to CR 7520).

**GO – What You Need to Do**

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

## Background

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In the Calendar Year (CY) 2004 Physician Fee Schedule (PFS) final rule with comment period (68 FR 63216; see <http://www.gpoaccess.gov/fr/retrieve.html>), the Centers for Medicare & Medicaid Services (CMS) established new G codes for the ESRD MCP. 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, and a higher payment is provided for two to three visits per month. To receive the highest payment amount, a physician would need 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 “we 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 Current Procedural Terminology (CPT) Editorial Panel created CPT codes to replace the G codes for monthly ESRD-related services, and CMS accepted the 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.

In the CY 2011 PFS final rule with comment period (75 FR 73295-73296), CMS required MCP physicians or practitioners to 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 as listed in the following table:

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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

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.

CR7520 clarifies Medicare policy to show that the MCP physician or practitioner may use other Medicare certified physicians or qualified nonphysician practitioners to provide some of the visits during the month. Visits must be furnished face-to-face by a physician, clinical nurse specialist, nurse practitioner, or physician's assistant.

The MCP physician or practitioner does not have to be present when these other physicians or practitioners provide the visit(s). The non-MCP physician or practitioner must be a partner, an employee of the same group practice, or an employee of the MCP physician or practitioner. For example, the physician or practitioner furnishing visits under the MCP may be either a W-2 employee or 1099 independent contractor.

When another physician is used to furnish some of the visits during the month, the physician who provides the complete assessment, establishes the patient's plan of care, and provides the ongoing management should bill for the MCP service.

When the qualified nonphysician practitioner performs the complete assessment and establishes the plan of care, then the MCP service should be billed under the National Provider Identifier of the qualified nonphysician practitioner (i.e., the clinical nurse specialist, nurse practitioner, or physician assistant).

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CR 7520 revises the Medicare Claims Processing Manual (Chapter 8, Section 140.1 (Payment for ESRD-related Services Under the Monthly Capitation Payment (Center Based Patients))), which is included as an attachment to that CR.

**Note:** Medicare contractors will not search their files to adjust claims already processed, but will adjust claims brought to their attention within a timely filing period.

## Additional Information

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The official instruction, CR 7520, issued to your carriers and A/B MACs regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2269CP.pdf> on the CMS website.

If you have any questions, please contact your carriers or A/B MACs at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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