

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



News Flash –

REVISED product from the Medicare Learning Network® (MLN)

- ["Hospital Outpatient Prospective Payment System,"](#) Fact Sheet, ICN 006820, Downloadable

MLN Matters® Number: MM7762

Related Change Request (CR) #: 7762

Related CR Release Date: April 26, 2012

Effective Date: October 1, 2012

Related CR Transmittal #: R2455CP

Implementation Date: October 1, 2012

Hospital Dialysis Services for Patients with and without End Stage Renal Disease (ESRD)

Provider Types Affected

This MLN Matters® Article is intended for hospitals that bill Fiscal Intermediaries (FIs) and/or A/B Medicare Administrative Contractors (MACs) for acute dialysis services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 7762, which informs hospitals about correctly billing Medicare for acute dialysis services furnished to hospital inpatients with ESRD. This article also clarifies how hospitals should report dialysis for outpatients who do not have ESRD but who need hemodialysis treatment.

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Background

Current Billing Practice

Hospitals have been billing Medicare on a 12x claim for acute dialysis services (those not covered and paid under the ESRD benefit described in 42 CFR 413.174) that are furnished to hospital inpatients with ESRD, using Healthcare Common Procedure Coding System (HCPCS) code G0257 (Unscheduled or emergency dialysis treatment for an ESRD patient in a hospital outpatient department that is not certified as an ESRD facility).

While Medicare covers these services under the Outpatient Prospective Payment System (OPPS), you should instead be reporting them under HCPCS code 90935 (Hemodialysis procedure with single physician evaluation). HCPCS G0257, by definition, is reserved for outpatients with ESRD and should be used only when the criteria specified in the "Medicare Claims Processing Manual," Chapter 4, Section 200.2, as revised and attached to CR7762.

HCPCS code G0257 may only be reported on Type of Bill (TOB) 13X (hospital outpatient service) or TOB 85X (Critical Access Hospital) because HCPCS code G0257 only reports services for hospital outpatients with ESRD and only these bill types are used to report services to hospital outpatients.

New Billing Policy

Effective for services furnished on and after October 1, 2012, claims that are for a TOB other than 13X (hospital outpatient) or 85X (Critical Access Hospital) will be returned to you for correction if HCPCS G0257 is reported on the claim. In these cases, either you have reported the incorrect code for the service furnished or you have reported the incorrect type of bill. The returned claim will include a remittance reason code of M20 showing "Missing/incomplete/invalid HCPCS."

In CR7762, CMS revises Section 200.2 of Chapter 4 of the "Medicare Claims Processing Manual" to clarify that HCPCS code 90935 (Hemodialysis procedure with single physician evaluation) may be reported and paid only if one of the following two conditions is met:

- The patient is a hospital inpatient with or without ESRD and has no coverage under Part A, but has Part B coverage. The charge for hemodialysis is a charge for the use of a prosthetic device. See the "Medicare Benefits Policy Manual," Chapter 15, Section 120. A, available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf> on the Centers for Medicare & Medicaid Services (CMS) website. The service must be reported on a Type of Bill 12X or Type of Bill 85X. See Chapter 6, Section 10 of the "Medicare Benefits Policy Manual" available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c06.pdf> for the criteria that must be met for services to be paid when a hospital inpatient has Part B coverage but does not have coverage under Part A; or

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- A hospital outpatient does not have ESRD and is receiving hemodialysis in the hospital outpatient department. The service is reported on a TOB 13X or I 85X.

Additional Information

The official instruction, CR7762, issued to your FI and A/B MAC regarding this change, may be viewed at <http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2455CP.pdf> on the CMS website. If you have any questions, please contact your FI or MAC at their toll-free number, which may be found at <http://www.cms.hhs.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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