CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2134	**Date: January 14, 2011**
	Change Request 7064

NOTE: Transmittal 2094, dated November 17, 2009 is rescinded and replaced by Transmittal 2134, dated January 14, 2011. This instruction is being reissued to correct the subject on the transmittal page only. All other material remains the same.

SUBJECT: End Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Consolidated Billing for Limited Part B Services

I. SUMMARY OF CHANGES: Section 153(b) of the Medicare Improvements for Patients and Providers Act (MIPPA) requires implementation of an End Stage Renal Disease (ESRD) bundled prospective payment system (PPS) effective January 1, 2011. Once implemented, the ESRD PPS will replace the current basic case-mix adjusted composite payment system and the methodologies for the reimbursement of separately billable outpatient ESRD related items and services. The ESRD PPS will provide a single payment to ESRD facilities, i.e., hospital-based providers of services and renal dialysis facilities, that will cover all the resources used in providing an outpatient dialysis treatment, including supplies and equipment used to administer dialysis in the ESRD facility or at a patient"s home, drugs, biologicals, laboratory tests, training, and support services.

EFFECTIVE DATE: January 1, 2011
IMPLEMENTATION DATE: January 3, 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
R	8/10 General Description of ESRD Payment
R	8/10.4 Deductible and Coinsurance
R	8/10.6 Amount of payment
R	8/20.1 Calculation of Case Mix Adjusted Composite Rate and Prospective payment System Rate
R	8/30 Determination and Publication of Composite Rate
R	8/40 Processing Requests for Composite Rate Exceptions
N	8/40.85 Pediatric Payment Model for ESRD PPS
N	8/50.15 Lab Services Included in the Prospective Payment System
N	8/50.25 Drugs and Biologicals Included in the Prospective Payment System
R	8/50.3 required Information for In-Facility claims Paid Under the Composite Rate and PPS
R	8/50.8 Training and Retraining
R	8/50.9 Coding for Adequacy of Dialysis, Vascular Access and Infection
R	8/60.1 Lab Services
R	8/60.2 Drugs Furnished in Dialysis Facilities
R	8/60.2 Drugs Furnished in Dialysis Facilities
R	8/60.2.1.1 Separately Billable ESRD Drugs
N	8/60.2.1.2 Facilities Billing for ESRD Drugs Equivalent to Injectable Drugs
R	8/60.2.2 Drug Payment Amounts for Facilities
R	8/60.3 Blood and Blood Services Furnished in Hospital Based and Independent Dialysis Facilities
R	8/60.4.3 Payment Amount for Epoetin Alfa (EPO)
R	8/60.4.3.1 Payment for Epoetin Alfa (EPO) in Other Settings
R	8/60.6 Vaccines Furnished to ESRD Patients
R	8/60.7.3 Payment Amount for Darbepoetin Alfa (Aranesp)
R	8/60.7.3.1 Payment for Darbepoetin Alfa (Aranesp) in Other Settings
R	8/70 Payment for Home Dialysis
R	8/70.1 Method Selection for Home Dialysis Payment

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:

Business Requirements

Manual Instruction

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

Attachment – Business Requirements

Pub. 100-04	Transmittal: 2134	Date: January 14, 2011	Change Request: 7064

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SUBJECT: End Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Consolidated Billing (CB) for Limited Part B Services

Effective Date: January 1, 2011

Implementation Date: January 3, 2011

I. GENERAL INFORMATION

A. Background: Section 153(b) of the Medicare Improvements for Patients and Providers Act (MIPPA) requires implementation of an End Stage Renal Disease (ESRD) bundled prospective payment system (PPS) effective January 1, 2011. Once implemented, the ESRD PPS will replace the current basic case-mix adjusted composite payment system and the methodologies for the reimbursement of separately billable outpatient ESRD related items and services. The ESRD PPS will provide a single payment to ESRD facilities, i.e., hospital-based providers of services and renal dialysis facilities, that will cover all the resources used in providing an outpatient dialysis treatment, including supplies and equipment used to administer dialysis in the ESRD facility or at a patient's home, drugs, biologicals, laboratory tests, training, and support services.

B. Policy: The ESRD PPS replaces the current basic case mix adjusted composite payment system and methodologies for the reimbursement of separately billable outpatient ESRD services. Specifically, the ESRD PPS combines payments for composite rate and separately billable services into a single base rate.

The per dialysis treatment base rate for adult patients is subsequently adjusted to reflect differences in wage levels among the areas in which ESRD facilities are located, by patient-level adjustments for case-mix, an outlier adjustment (if applicable), facility-level adjustments, a training add-on (if applicable), adjustments specific to pediatric patients (dialysis patients that are under the age of 18), and a budget neutrality adjustment during the transition period.

The patient-level adjustments are patient-specific case-mix adjusters that were developed from a two-equation regression analysis that encompasses composite rate and separately billable items and services. Included in the case-mix adjusters are those variables that are currently used in basic case-mix adjusted composite payment system, that is, age, body surface area (BSA), and low body mass index (BMI). In addition to those adjusters that are currently used, the ESRD PPS will also incorporate adjustments for six co-morbidity categories and an adjustment for the onset of renal dialysis.

ESRD facilities that are treating patients with unusually high resource requirements as measured through their utilization of identified services beyond a specified threshold will be entitled to outlier payments, that is, additional payment beyond the otherwise applicable case-mix adjusted prospective payment amount. ESRD outlier services are the following items and services that are included in the ESRD PPS bundle: (1) ESRD-related drugs and biologicals that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B; (2) ESRD-related laboratory tests that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B; (3) medical/surgical supplies, including syringes, used to administer

ESRD-related drugs that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B; and (4) renal dialysis service drugs that were or would have been, prior to January 1, 2011, covered under Medicare Part D, notwithstanding the delayed implementation of ESRD-related oral-only drugs effective January 1, 2014. Services not included in the PPS that remain separately payable, including blood and blood processing, preventive vaccines, and telehealth services, are not considered outlier services.

The facility-level adjustments include adjusters to reflect urban and rural differences in area wage levels using an area wage index developed from Core Based Statistical Areas (CBSAs). The facility-level adjustments also include an adjuster for facilities treating a low volume of dialysis treatments. Facilities that are certified to furnish training services will receive an add-on payment amount of $33.44 which is adjusted by the geographic area wage index to account for an hour of nursing time for each training treatment that is furnished. The training add-on applies to both PD and HD training treatments.

The pediatric payment model applies to all dialysis patients that are under the age of 18. The per treatment base rate as it applies to pediatric patients is the same base rate used for adult patients, and is also adjusted by the area wage index. However, due to the lack of statistical robustness, the base rate for pediatric patients is not adjusted for case-mix based on specific comorbidities as for adult patients. Instead, the pediatric payment adjusters are increased by 10.5 percent to reflect higher total payments for pediatric composite rate and separately billable services, compared to adult patients. The adjusters have also been increased by an additional 6.7 percent to account for patient level adjusters to the base rate that apply for adult patients, but that are not applicable for pediatric patients. The pediatric model also incorporates separate adjusters based on two age groups (<13, 13-17) and dialysis modality (hemodialysis, peritoneal dialysis). Treatments furnished to pediatric patients can qualify for a training add-on payment, when applicable, and are eligible for an outlier adjustment. However pediatric dialysis treatments are not eligible for the low-volume adjustment.

The ESRD PPS provides ESRD facilities a 4-year phase-in (transition) period under which they would receive a blend of payments under the prior case-mix adjusted composite payment system and the new ESRD PPS. For CY 2011, we must continue to update the basic case-mix composite payment system for purposes of determining the composite rate portion of the blended payment amount. We will issue a change request with updates to the composite payment rate, the drug add-on adjustment to the composite rate, the wage index adjustment, and the budget neutrality adjustment. This change request will be issued at the time the physician fee schedule is finalized. In addition, for purposes of the composite rate portion of the blended payment amount, an add-on of $0.49 will be added to the adjusted composite payment to account for ESRD related drugs and biologicals that are currently separately paid under Part D and are now included in the ESRD PPS.

The ESRD PPS base rate applicable for both adult and pediatric ESRD patients effective January 1, 2011 is $229.63. This base rate will be wage adjusted as mentioned above where the labor-related share of the base rate from the ESRD PPS market basket is .41737, and the non labor-related share of the base rate is $133.79 ((229.63 * (1-.41737) = $133.79). During the transition, the labor-related share of the case-mix adjusted composite payment system will remain .53711. Once the base rate is wage adjusted, any applicable patient-level adjustments, facility-level adjustments, outlier adjustments, and training add-on payments (adjusted for area wage levels) are applied to determine the payment rate for a dialysis treatment. Once the payment rate for the dialysis treatment is determined, the last item in the computation to determine the final payment rate is the application of the transition budget neutrality factor of .969, that is, a 3.1 percent reduction.

The **ESRD PRICER** will provide the payment for existing composite rate, the new ESRD PPS payment rate, and the outlier payment (when applicable). These reimbursement amounts must be blended during a transition period for all ESRD facilities except those opting out of the transition and electing to be paid 100 percent of the payment amount under the new ESRD PPS. Providers wishing to opt out of the transition period blended rate must notify their Medicare Contractor on or before November 1, 2010. Providers shall not submit claims spanning date of service in 2010 and 2011.

The blended rate is determined as follows:

2011 – 75 percent of the old payment methodology and 25 percent of new PPS payment
2012 – 50 percent of the old payment methodology and 50 percent of the new PPS payment
2013 – 25 percent of the old payment methodology and 75 percent of the new PPS payment
2014 – 100 percent of the PPS payment

New Adjustments applicable to the Adult Rate:

Comorbid Adjustments: The new ESRD PPS provides for 3 categories of chronic comorbid conditions and 3 categories for acute comorbid conditions. A single adjustment will be made to claims containing one or more of the comorbid conditions. The highest comorbid adjustment applicable will be applied to the claim. The acute comorbid adjustment may be paid no greater than 4 consecutive months for any reported acute comorbid condition unless there is a reoccurrence of the condition.

The 3 chronic comorbid categories eligible for a payment adjustment are: Hereditary hemolytic and sickle cell anemia, Monoclonal gammopathy (in the absence of multiple myeloma) and Myelodysplastic syndrome. The 3 acute comorbid categories eligible for a payment adjustment are: Bacterial Pneumonia, Gastrointestinal Bleeding , and Pericarditis.

Onset of Dialysis Adjustment: An adjustment will be made for patients that have Medicare ESRD coverage during their first 4 months of dialysis. This adjustment will be determined by the dialysis start date in the Common Working File as provided on the CMS Form 2728 completed by the provider. When the onset of dialysis adjustment is provided, the claim is not entitled to a comorbid adjustment or a training adjustment.

Low Volume Facility Adjustment: Providers will receive an adjustment to their PPS rate when the facility furnished less than 4,000 treatments in each of the three years preceding the payment year and has not open, closed, or received a new provider number due to a change in ownership during the 3 years preceding the payment year. The provider must notify their Medicare Contractor if they believe they are eligible for the low volume adjustment. Contractors must validate the eligibility and update the provider specific file.

Change in Processing Home Dialysis Claims:

For claims with dates of service on or after January 1, 2011, the payment of home dialysis items and services furnished under Method II, regardless of home treatment modality, are included in the ESRD PPS payment rate. Therefore, all home dialysis claims must be submitted by a renal dialysis facility and will be processed as method I claims. This CR instructs the DME MACs to stop separate payment to suppliers for Method II home dialysis items and services for claims with dates of service on or after January 1, 2011.

Consolidated Billing:

This CR provides an ESRD consolidated billing requirement for limited Part B services included in the ESRD facility bundled payment. Certain lab services and limited drugs and supplies will be subject to Part B consolidated billing and will no longer be separately payable when provided for ESRD beneficiaries by providers other than the renal dialysis facility. Should these lab services, and limited drugs be provided to a beneficiary, but are not related to the treatment for ESRD, the claim lines must be submitted with the new AY modifier to allow for separate payment outside of ESRD prospective payment system. ESRD facilities billing for any labs or drugs will be considered part of the bundled PPS payment unless billed with the modifier AY.

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	
	BRs FOR PRICING CHANGES (Institutional Claims Only)										
7064.1	Medicare contractors shall load the new ESRD PPS Pricer.						X				
7064.2	Medicare contractors shall revise the outpatient provider file layout to include the newly required / redefined fields for renal dialysis facilities as follows (these fields must not be blank and must contain one of the valid indicators provided below): Field 49: Y = ESRD Provider waived blended payment, pay full PPS N = ESRD Provider did not waive blended payment Field 57: For ESRD Facilities Y= Low Volume Facility N= Not a Low Volume Facility						X				
7064.2.1	Medicare contractors shall update the provider file for renal dialysis facilities to include the newly required / redefined fields for renal dialysis facilities and update any revised CBSA codes if applicable.	X		X							
7064.2.2	Medicare contractors shall send the newly required outpatient provider specific fields to the ESRD Pricer: • Field 49 • Field 57						X				
7064.2.3	Medicare contractors shall apply the blended rate applicability to the 72x bill types based on the indicator 49 received in the outpatient provider specific file.						X				ESRD PRICER
7064.2.4	PRICER shall apply the low volume adjustment to the PPS rate when the indicator in field 57 is populated with "Y"										ESRD PRICER

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	
7064.3	Medicare contractors shall send the following additional data from the 72x bill type to the ESRD PRICER in the claim file: • total number of dialysis sessions billed on the claim for outlier calculation (total number of lines with revenue codes 0821, 0831, 0841, 0851, 0881) • line item date of service for each dialysis revenue code sent to the PRICER (needed for onset of dialysis adjustment)						X				
7064.3.1	Medicare systems shall reject any lines reporting revenue code 0880.						X				
7064.3.1.1	Medicare contractors shall apply to line items reporting revenue code 0880 remittance advice remark code M81: You are required to code to the highest level of specificity	X		X			X				
7064.3.1.2	Medicare contractors shall assign provider liability to revenue code 0880 lines (assign group code CO)	X		X			X				
7064..3.2	PRICER / PC PRICER shall remove revenue code 0880 for pricing claims with dates of service on or after January 1, 2011										ESRD PRICER
7064.4	Medicare contractors shall continue to calculate the erythropoiesis stimulating agent (ESA) monitoring policy reductions.						X				
7064.5	For providers that did not opt into the full PPS, Medicare contractors shall apply the separately billable payments at the line level for non-dialysis revenue codes after the applicable blended adjustment: Note: ESA monitoring policy reduction should occur prior to blended adjustment being made. 2011 – 75 percent 2012 - 50 percent 2013 – 25 percent 2014 – 0 percent						X				
7064.5.1	Medicare contractors shall return claims to the provider with dates of service spanning 2010 and 2011.						X				
7064.6	Medicare contractors shall exempt from the PPS payment and continue to pay the following services based on existing payment policy (do not apply the blended rate):						X				

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	
	• Telehealth services billed with HCPCS Q3014 (see 100-4, chapter 12) • Preventive vaccines covered by Medicare (see 100-4, chapter 18 for all vaccine and administration codes billable) • Blood and blood services										
7064.7	Medicare contractors shall continue to send the dialysis reimbursement amount to the ESRD PRICER for providers not paid under the existing composite rate method (current exceptions to the composite rate).						X				
7064.8	Medicare contractors shall continue to send current exception amounts for dialysis training to the ESRD PRICER.						X				
7064.9	Medicare contractors shall compare the claim from date to the dialysis start date.									X	
7064.9.1	Medicare contractors shall reject the claim only if the dialysis start date is within 4 months of the claim from date.									X	
7064.9.2	Medicare contractors shall create a new trailer to return the dialysis start date.						X			X	
7064.9.3	Medicare contractors shall allow this reject code to be overridden.						X			X	
7064.9.4	Medicare contractors shall send the dialysis start date in the claim file to the ESRD PRICER when receiving the CWF edit trailer for dialysis start date within 4 months.						X				
7064.9.4.1	Medicare contractors shall put the edit code in the override field when sending the start date to the PRICER.						X				
7064.9.5	PRICER shall apply the new onset of dialysis adjustment to the PPS rate for dialysis revenue code lines when the date of onset is within 4 months (120 days) of the line item date of service.										ESRD PRICER
7064.9.5.1	PRICER shall not apply comorbid adjustments or training adjustments when the onset of dialysis adjustment is applicable.										ESRD PRICER
7064.10	PRICER shall not apply the comorbid adjustments, onset of dialysis adjustment, low volume provider adjustment, BSA, BMI and Age adjustments to claims for pediatric patients (under 18 yrs of age).										ESRD PRICER
7064.11	PRICER shall assign the pediatric hemodialysis rate										ESRD

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	
	to revenue code 0881 (ultrafiltration) when reported on a pediatric claim.										PRICER
7064.12	Medicare contractors shall calculate the total payments for services applicable to the outlier and reflect the total on the claim with the payer only value code 79. Note: Services that remain separately payable from the PPS are not to be included in this total (i.e. blood, vaccines, telehealth and services reporting modifier AY).						X				
7064.12.1	To calculate the outlier amount for value code 79, Medicare contractors shall use existing payment methodologies for the list of outlier services on attachment 3 (i.e. drugs ASP+6%, labs according to the 50/50 rule, etc).						X				
7064.12.1.1	Medicare contractors shall add any new drug not on attachment 3, when reported with revenue 0636 and a HCPCS that is effective on or after January 1, 2011 with an associated ASP rate on file to the value code 79 for outlier consideration.						X				
7064.12.1.2	Medicare contractors shall include in the outlier total (value code 79) the oral drugs reported with revenue code 0250 with an NDC.						X				
7064.12.1.3	Medicare contractors shall not pay and shall not include in the value code 79 revenue code 0250 when reported without an NDC.						X				
7064.12.1.4	Medicare contractors shall use the list of NDC prices provided by CMS for the calculation of oral drugs for reporting in the value code 79. See attachment 3 for NDC Pricing List. NOTE: The oral drugs priced by NDC are for possible outlier payments only and do not receive separate payment.						X				
7064.12.1.5	Medicare contractors shall calculate the oral equivalent drugs for outlier by multiplying the NDC quantity field and the NDC unit price provided by CMS in attachment 3 of the NDC drug and then add the dispensing fee of $1.73. Note: Dispensing fee only payable once per claim for each NDC.						X				
7064.12.1.6	Medicare contractors shall include the total amount for the oral drug equivalents in the value code 79 for outlier						X				

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	
7064.12.2	Medicare contractors shall send the ESRD PRICER the total calculated payment for the outlier services under value code 79.						X				
7064.12.3	Medicare contractors shall not allow a provider to submit a 72x claim with the payer only value code 79.						X				
7064.12.4	PRICER shall determine the applicability of outlier payment based on the value code 79 amount and the number of dialysis sessions.										ESRD PRICER
7064.13	Medicare contractors shall not make revenue code 0250 a separately payable service under the existing composite rate portion of the blended payment.						X				
7064.14	Medicare contracts shall ensure the only supplies (rev codes 27x, 62x) receiving separate payment under the composite rate portion of the blended payment are for administration of separately billable drugs under the composite rate (A4913 and A4657).	X		X			X				
7064.15	Medicare contractors shall ensure supplies do not receive separate payment under the PPS portion of the payment even when modifier AY is present except for A4913 and A4657 which may be separately paid with modifier AY. Note: A4913 and A4657 are outlier services on attachment 3 but are not counted toward outlier if the AY modifier is present.	X		X			X				
7064.16	Medicare contractors shall accept the following reimbursement amounts from the ESRD PRICER: • Composite rate and the adjusted composite rate for the blend • New PPS payment and the adjusted PPS rate for the blend • Per treatment outlier amount and adjusted per treatment outlier amount.						X				ESRD PRICER
7064.16.1	Medicare contractors shall display the PRICER calculated amounts on the claim record.						X				
7064.16.2	When field 49 of the outpatient provider file contains "N", PRICER returns all 6 totals.						X				ESRD PRICER
7064.16.2.1	Medicare contractors show the line payment amount for each dialysis session calculated as follows: Adjusted composite rate+adjusted PPS rate+adjusted outlier amount.						X				

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	
7064.16.2.2	Medicare contractors shall calculate the total claim payment by totaling the following: (Total adjusted rate for all dialysis sessions + adjusted separately billables) x .969 (transition budget neutrality) + the full payment for any PPS excluded services (i.e. non-ESRD services with modifier AY, telehealth, preventive vaccines and blood).						X				
7064.16.3	When field 49 of the outpatient provider file contains "Y", PRICER returns the PPS rate and the outlier amount the remaining price fields are populated with 0.										ESRD PRICER
7064.16.3.1	Medicare contractors show the line payment amount for each dialysis session calculated as follows: PPS rate+ outlier amount.						X				
7064.16.3.2	Medicare contractors shall calculate the total claim payment by totaling the following: Total of PPS rate for all dialysis sessions x .969 + any PPS excluded services (i.e. non-ESRD services with modifier AY, telehealth, preventive vaccines and blood).						X				
7064.16.3.3	Medicare contractors shall display the total outlier payment under value code 17. (total outlier payment calculated as per treatment outlier with adjustment when applicable x number of dialysis sessions)						X				
7064.17	For claims paid fully under the PPS, Medicare contractors shall ensure that line items covered in the bundle without separate payment remain shown as covered services with remittance advice with reason codes 97 and CO (contractual obligation),	X		X			X				
	BRs FOR TRACKING AND PAYING COMORBID ADJUSTMENTS										
7064.18	Medicare contractors shall use the list of comorbid diagnosis codes provided by CMS (see attachment 8)						X				
7064.18.1	Medicare contractors shall append a payer only condition code for each comorbid category present on the claim. Acute comorbids: • MA – GI Bleed • MB-Pneumonia • MC –Pericarditis Chronic comorbids:						X				

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	
	• MD – Myelodysplastic syndrome • ME- Hereditary hemolytic and sickle cell anemia category • MF- Monoclonal gammopathy										
7064.18.2	Medicare contractors shall send the payer only condition code(s) to the PRICER.						X				
7064.18.3	Medicare contractors shall not allow providers to submit 72x claims with the payer only conditions MA, MB, MC, MD, ME, MF.						X				
7064.19	PRICER shall assign and Medicare contractors shall accept the following return codes: • 1x- No comorbid payment • 2x – Paying on the MA category • 3x – Paying on the MB category • 4x – Paying on the MC category • 5x – Paying on the MD category • 6x – Paying on the ME category • 7x – Paying on the MF category Note: Order is from highest paying to lowest paying adjustment. Pediatric claims will always be assigned 1x.						X				ESRD PRICER
7064.20	Medicare contractors shall establish a CWF beneficiary auxiliary file to track the acute comorbid categories reported (condition code MA, MB, MC), including date of onset for each category, from and through claim dates and a payment indicator (see attachment 2).									X	
7064.20.1	Medicare contractors shall update the auxiliary file with each claim that contains a condition code MA, MB, MC.									X	
7064.20.2	Medicare contractors shall create a new onset date on the auxiliary file when a comorbid reoccurrence is present on the claim. Note: Each category will have a reoccurrence condition code assigned. Condition codes to be defined prior to implementation. Condition code H3 – reoccurrence of MA category Condition code H4– reoccurrence of MB category Condition code H5 - reoccurrence of MC category									X	
7064.20.2.1	Medicare Contractors shall accept the new condition codes H3, H4 and H5 when reported on the						X				

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	
	72x bill type effective January 1, 2011. (Note: These codes are limited by the NUBC to the 72x bill type only).										
7064.21	Medicare contractors shall ensure that an acute comorbid adjustment is applied for the first month reported and 3 consecutive months even if not reported. (this applies only to the MA, MB, MC categories).						X			X	
7064.21.1	When the return code indicates payment for a comorbid category that is not the highest paying comorbid payable, Medicare contractors shall return an edit trailer indicating the highest allowable comorbid category that qualifies for an adjustment.									X	
7064.21.2	Medicare contractors shall determine if the return code indicates payment for a comorbid category that has been reported on an incoming claim for more than 4 consecutive months.									X	
7064.21.2.1	When the return code indicates payment for a comorbid category that exceeds 4 consecutive months, the Medicare contractors shall return a edit trailer indicating (1) if no comorbid categories (condition codes MA, MB, MC) reported qualify for an adjustment (i.e. all over 4 consecutive months) (2) indicate the highest allowable comorbid category that qualifies for an adjustment if the initial category return code is not eligible.									X	
7064.21.3	Medicare contractors shall send the appropriate return code to PRICER for the edit trailer received. (i.e. no comorbid eligible = return code 1x, MA category eligible = 2x, MB category eligible = 3x, MC category eligible = 4x)						X				
7064.21.4	Medicare contractors shall update the comorbid auxiliary screen with a payment indicator to indicate which comorbid category is paid.									X	
7064.22	PRICER shall accept the return code and apply the comorbid adjustment based on the return code.										ESRD PRICER
7064.23	Medicare contractors shall append CARC B22 (This payment is adjusted based on the diagnosis) to the provider remittance when the comorbid category reported by the PRICER for payment is revised based on the CWF auxiliary file.	X		X			X				

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	
7064.24	Medicare contractors shall identify when claims paid out of sequence resulted in claim(s) receiving or not receiving the correct comorbid adjustment.									X	
7064.25	Medicare contractors shall create an IUR (informational unsolicited response) with all the required data to identify the claim(s) that need to be adjusted to correct comorbid adjustments.									X	
7064.25.1	Upon receipt of the IUR, Medicare systems shall perform an automated adjustment to the paid 72x claim to correct the comorbid adjustment.						X				
7064.26	Medicare systems shall allow for a Medicare review override for each comorbid adjustment at onset in the event that medical documentation does not support the adjustment.						X			X	PRICER
	BRS APPLICABLE TO ALL NEW ESRD CB EDITS										
7064.27	Medicare systems shall create a new edit for ESRD Consolidated Billing Edits									X	
7064.27.1	Medicare systems shall accept the new edit for ESRD Consolidated Billing Edits						X	X			
7064.27.2	Medicare contractors shall assign group code CO – contractual obligation (provider liability).	X	X	X	X		X				
7064.27.3	Medicare contractors shall return Claims Adjustment Reason Code (CARC) 109: Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	X	X	X	X		X				
7064.27.4	Medicare contractors shall return new Remittance Advice Remark Code (RARC) N538 "A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents".	X	X	X	X		X				
7064.27.5	Medicare contractors shall return new Medicare Summary Notice (MSN) code 4.12 English "This service has been denied/rejected since payment was made to your End Stage Renal Disease (ESRD) dialysis facility." Spanish "Este servicio le ha sido denegado/rechazado porque se le hizo el pago a su centro de diálisis de ESRD."	X	X	X	X		X				
7064.28	Medicare systems shall develop an overall ESRD CB override code that will be disclosed in the CWF						X	X		X	

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	
	documentation to be used at the discretion of the A/B MACs/carriers and fiscal intermediaries in accordance with CMS instructions										
7064.29	Medicare contractors shall accept the new modifier AY: Item or service furnished to an ESRD patient that is not for the treatment of ESRD										IOCE
	BRs FOR METHOD II SERVICES BILLED TO THE DME MACs										
7064.30	Effective for claims with dates of service (DOS) of January 1, 2011 and later, contractors shall deny claims containing Method II home dialysis service HCPCS codes, when billed separately.		X						X		
7064.30.1	Per 7064.30, contractors shall deny claims for Method II drugs (HCPCS codes Q4081, J0882 and J0886).		X						X		
7064.30.2	Per 7064.30, contractors shall deny claims for Method II supplies and equipment, as specified in Attachment 5, "ESRD Supply HCPCS Not Payable to DME Suppliers".		X						X		
7064.31	Medicare systems shall continue to allow separate billing for ESRD supply HCPCS codes subject to PPS CB (see Attachment 4) when submitted by suppliers for services not related to the beneficiary's ESRD dialysis treatment and billed with the modifier AY.		X						X		
7064.32	Effective for claims with dates of service (DOS) of January 1, 2011 and later, Medicare systems shall deny claims for ESRD supply HCPCS code subject to consolidated billing (CB) when billed on a CMS-1500 or electronic equivalent when a covered 72x claim is in history with overlapping dates of service, the ordering physician is listed in the MCP database, and the ESRD supply claims do not contain modifier AY .		X						X	X	
7064.33	Contractors shall refer to Attachment 4 for a list of ESRD supply HCPCS codes subject to ESRD CB.		X							X	
7064.34	Contractors shall pay claims for ESRD supplies subject to ESRD CB when billed on a CMS-1500 or electronic equivalent when a covered 72x claim is in history with overlapping dates of service and the ordering physician is not listed in the MCP database.		X						X	X	
7064.35	Contractors shall pay claims for ESRD supplies		X							X	

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	
	subject to ESRD CB when billed on a CMS-1500 or electronic equivalent if the ESRD supply claims contain modifier AY.										
7064.36	Contractors shall create an informational unsolicited response (IUR) when a paid claim in history has covered ESRD supplies, the ordering physician is listed in the MCP database, the claim does not contain modifier AY, and an incoming 72x claim has overlapping dates of service.		X						X	X	
7064.37	Upon receipt of IUR, contractors shall perform an automated adjustment to the paid ESRD supply claim and deny the ESRD supplies at the line level for ESRD CB.		X						X	X	
7064.37.1	Contractors shall allow the processing of the 72x claim.									X	
7064.37.2	Upon receipt of IUR, contractors shall perform an automated adjustment to the paid ESRD supply claim and deny the ESRD supplies at the line level for ESRD CB.		X							X	
	BRs for OUTPATIENT BILLING OF LAB SERVICES SUBJECT TO CONSOLIDATED BILLING										
7064.38	Medicare systems shall reject at the line level on incoming outpatient TOBs 13x, 14x and 85x billing for ESRD lab services subject to CB (see attachment 6 for list of labs) that do not contain modifier AY or HCPCS G0257 when overlapping the from and through date of a covered 72x claim is in history.						X			X	
7064.39	Medicare systems shall create an IUR when a paid outpatient TOB 13x, 14x or 85x in history has covered lab services subject to ESRD CB and does not contain modifier AY or HCPCS G0257 and an incoming 72x claim has overlapping dates of service.									X	
7064.39.1	Medicare systems shall allow the processing of the 72x claim.						X			X	
7064.39.2	Upon receipt of the IUR, Medicare systems shall perform an automated adjustment to the paid outpatient claim TOB 13x, 14x or 85x and reject the lab services at the line level for ESRD consolidated billing (CB).						X				
7064.40	Medicare systems shall consider all labs on the 72x bill type to be included in the bundled PPS, paid						X				

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	
	separately only for the transition period unless the modifier AY is reported on the line.										
	BRs FOR CARRIER/MAC PROCESSING FOR LAB										
7064.41	Contractors shall refer to attachment 6 for a list of lab services subject to ESRD consolidated billing (CB).	X			X					X	
7064.42	Upon receipt of reject from CWF, contractors shall deny claims for lab services subject to ESRD CB when billed on a CMS-1500 or electronic equivalent when a covered 72x claim is in history with overlapping dates of service, the ordering physician is listed in the MCP database, and the lab services do not contain modifier AY.	X			X					X	
7064.42.1	Contractors shall return the appropriate message codes per the requirements in BRs 7064.27.2 – 7064.27.5.	X			X						
7064.43	Contractors shall deny claims for lab services subject to ESRD CB when billed on a CMS-1500 or electronic equivalent when a covered 72x claim is in history with overlapping dates of service, the ordering physician is listed in the MCP database, and the lab services do not contain modifier AY.	X			X					X	
7064.44	Contractors shall pay claims for lab services subject to ESRD CB when billed on a CMS-1500 or electronic equivalent when a covered 72x claim is in history with overlapping dates of service and the ordering physician is <u>not</u> listed in the MCP database.	X			X					X	
7064.45	Contractors shall pay claims for lab services subject to ESRD CB when billed on a CMS-1500 or electronic equivalent if the lab services contain modifier AY.	X			X					X	
7064.46	Contractors shall pay claims for lab services subject to ESRD CB when billed on a CMS-1500 or electronic equivalent when there is <u>no</u> covered 72x claim in history, the ordering physician is listed in the MCP database, <u>and</u> the lab services are billed without modifier AY.	X			X					X	
7064.46.1	Contractors shall create an informational unsolicited response (IUR) when a paid claim in history has covered lab services, the ordering physician is listed in the MCP database, does not contain modifier AY, and an incoming 72x claim has overlapping dates of									X	

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	
	service.										
7064.46.2	Contractors shall allow the processing of the 72x claim.						X			X	
7064.46.3	Upon receipt of IUR, contractors shall perform an automated adjustment to the paid lab claim and deny the lab services at the line level for ESRD CB.	X			X			X		X	
7064.47	Upon implementation of the ESRD CB, contractors shall sunset 50/50 rule modifiers CD, CE and CF only for claims submitted on CMS-1500 forms or the electronic equivalent. 50/50 Rule modifiers shall remain valid for use on the 72x claim for the purposes of calculating the blended transition rate and outlier.	X			X						
	BRs FOR OUTPATIENT AND PART B DRUGS SUBJECT TO ESRD CONSOLIDATED BILLING										
7064.48	Contractors shall reject at the line level incoming outpatient TOBs 13x, 14x, 85x for drugs subject to ESRD CB (see attachment 7) that do not contain modifier AY or HCPCS G0257 when overlapping the from and through date of a covered 72x claim is in history.	X					X			X	
7064.48.1	Contractors shall reject for ESRD CB outpatient TOBs 13x, 14x or 85x for drugs subject to the ESRD CB at the line level.	X					X				
7064.49	Contractors shall reject incoming Part B claims for drugs subject to ESRD CB (see attachment 7) from rendering practitioners included on the Monthly Capitation Payment (MCP) Data File that do not contain modifier AY or HCPCS G0257 when a covered 72x claim is in history with overlapping dates of service.									X	
7064.49.1	Contractors shall deny the claim lines rejected to them in 7064.49.	X			X						
7064.49.2	Contractors shall return the appropriate message codes per the requirements in BRs 7064.27.2 – 7064.27.5.	X		X	X		X				
7064.50	Contractors shall allow the processing of the 72x claim.						X			X	
7064.51	Contractors shall create an IUR when a paid outpatient TOB 13x, 14x, or 85x in history has covered drugs subject to ESRD CB that do not									X	

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	
	contain modifier AY or HCPCS G0257 and an incoming 72x claim has overlapping dates of service.										
7064.51.1	Upon receipt of the IUR, Contractors shall perform an automated adjustment to the paid outpatient claim and reject the drug service(s) at the line level for ESRD CB.	X					X				
7064.52	Contractors shall create an IUR when a paid Part B practitioner claim in history has covered drugs subject to ESRD CB from a rendering practitioner included on the MCP Data File that do not contain modifier AY or HCPCS G0257 and an incoming 72x claim has overlapping dates of service.									X	
7064.52.1	Upon receipt of the IUR, Contractors shall perform an automated adjustment to the paid Part B practitioner claim to recoup payment.	X			X			X			
7064.52.2	Contractors shall return the appropriate message codes per the requirements in BRs 7064.27.2 – 7064.27.5.	X			X			X			
7064.53	Contractors shall not pay separately for any drugs on the 72x bill type except for during the transitional period, unless the modifier AY is present.						X				
7064.54	Contractors shall not pay for the drugs subject to the ESRD CB on the 72x bill type regardless of whether modifier AY is present or not (see attachment 7).						X				
	BRs for METHOD 1 AND 2 SELECTIONS										
7064.55	Medicare contractors shall no longer enter method selection forms that become effective on or after 1/1/2011 into the standard systems.	X		X							
7064.56	Medicare contractors shall treat all 72x claims with condition code 74 as method 1 home dialysis claims.						X				
7064.57	Medicare contractors shall not edit for the presence of a method selection on file for home dialysis claims (72x bill type with condition code 74) with dates of service on or after January 1, 2011.						X				
7064.58	Medicare systems shall send claims for beneficiaries with method 2 selection on file with dates of service on or after 1/1/2011 to the ESRD PRICER. Note: Effective 1/1/2011 Method 2 goes away and those claims will be paid and processed the same as Method 1.						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	
7064.59	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	X	X						

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:
7064.16.2.2\ 7064.16.3.2	Part A MSP claims shall continue to be sent to the outpatient MSPAY sub-modules (MSPPAYOL and MSPPAYAO) in MSPPAY for Medicare secondary payment calculations.

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

V. CONTACTS

Pre-Implementation Contact(s): Claims Processing: Institutional Claims Wendy.Tucker@cms.hhs.gov; Practitioner Claims Leslie.Trazzi@cms.hhs.gov; Independent Labs Claims Felicia.Rowe@cms.hhs.gov; DME Claims Susan.Webster@cms.hhs.gov
MSP : Richard.Mazur@cms.hhs.gov; ESRD PPS Policy: Michelle.Cruse@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

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

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)*, use 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.

Attachments

Medicare Claims Processing Manual

Chapter 8 - Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims

Table of Contents
(Rev.2134, Issued: 01-14-11)

10 - General Description of ESRD Payment

(Rev. 2134, Issued: 01-14-11, Effective: 01-01-11, Implementation: 01-03-11)

PRM-1-2702, RDF-206

See the Medicare Benefit Policy Manual, Chapter 11, for a general description of coverage policies relating to the ESRD benefit.

ESRD benefits may be paid in several ways at several sites, either in a hospital setting, an independent facility or at home. Depending on the location or the type of dialysis performed, rates may differ. ESRD facilities are paid at a composite rate and for beneficiaries dialyzing at home benefits may be paid under a composite rate (Method I) or as a series of separately billable services (Method II). Home dialysis patients choose between the two methods.

Renal dialysis facilities develop a unit charge for the range of services normally provided, taking into account variations among patients (complicated and uncomplicated situations) since it is the overall dialysis service that is covered. Any auxiliary service that cannot be included in the single unit charge for dialysis services as an integral part of a maintenance dialysis must be includable under another specific coverage provision of the Medicare law, or be denied. For example, the Medicare law excludes from coverage out of hospital drugs except when specified conditions are met with respect to the physician's involvement. Furthermore, when the conditions are met, the drug and injection charges must be billed to the carrier by the physician. Medicare benefits are secondary, during a coordination period, to benefits payable under a Group Health Plan (GHP) in the case of individuals entitled to benefits on the basis of ESRD. See the Medicare Secondary Payer (MSP) Manual, Chapter 2, for further information on the coordination period and when Medicare would pay secondary to GHP insurance.

Effective January 1, 2011 Section 153b of the Medicare Improvements for Patients and Providers Act (MIPPPA) requires the implementation of an ESRD bundled prospective payment system (ESRD PPS). The ESRD PPS provides a single payment to ESRD facilities that will cover all of the resources used in furnishing an outpatient dialysis treatment, including supplies and equipment used to administer dialysis (in the ESRD facility or at a patient's home), drugs, biologicals, laboratory tests, training, and support services.

10.4 - Deductible and Coinsurance

(Rev. 2134, Issued: 01-14-11, Effective: 01-01-11, Implementation: 01-03-11)

RDF-112, RDF-114

The beneficiary is responsible for any unmet deductible and for coinsurance. For *renal dialysis* services *furnished* in independent *ESRD* facilities *or in* hospital-*based providers of services, in the current basic case-mix composite rate payment system the coinsurance is based on the composite rate and* other payment rates for services paid in addition to the composite rate. *Effective January 1, 2011, if the ESRD facility chooses to be reimbursed a blended payment rate during the transition (discussed in section 20.1 of this manual),*

the beneficiary pays co-insurance on the final blended payment amount. If the ESRD facility elects to be reimbursed 100 percent by the ESRD PPS then the beneficiary pays co-insurance on the ESRD PPS base rate and all applicable adjustments.

10.6 - Amount of Payment

(Rev. 2134, Issued: 01-14-11, Effective: 01-01-11, Implementation: 01-03-11)

After the beneficiary's Part B deductible is met, FIs pay 80 percent of the facility composite payment rate for each in-facility outpatient maintenance dialysis treatment and 80 percent of this same amount for all home dialysis patients who elect to have their dialysis care reimbursed under Method I. (See the Medicare Benefit Policy Manual, Chapter 11). *Effective for dates of service beginning January 1, 2011, after the beneficiary's Part B deductible is met, the FIs pay 80 percent of the ESRD PPS base rate and all applicable adjustments (or the blended payment amount if the facility chooses to transition), for each outpatient maintenance dialysis treatment furnished to the ESRD beneficiary in the ESRD facility or at the beneficiary's home.*

20 - Definitions Related to Calculating *the* Composite Rate *and the ESRD Prospective Payment System Rate*

(Rev.2134, Issued: 01-14-11, Effective: 01-01-11, Implementation: 01-03-11.)

See Chapter 11 of the Medicare Benefit Policy Manual for definitions relating to ESRD and the composite rate.

20.1 – Calculation of *the Basic* Case-Mix Adjusted Composite Rate *and the ESRD Prospective Payment System Rate*

(Rev. 2134, Issued: 01-14-11, Effective: 01-01-11, Implementation: 01-03-11)

A case mix methodology adjusts the composite payment rate based on a limited number of patient characteristics. Variables for which adjustments will be applied to each facility's composite rate include age, body surface area (BSA), and low body mass index (BMI). These variables are determined in the ESRD PRICER to calculate the final composite rate (including all other adjustments).

The following table contains claim data required to calculate a final ESRD composite rate:

UB-04 Claim Items	**ASC X12N 837i**
Through Date	2300 | DTP segment | 434 qualifier
Date of Birth	2010BA | DMG02
Condition Code (73 or 74)	2300 | HI segment | BG qualifier

Value Codes (A8 and A9) / Amounts	2300 | HI segment | BE qualifier
Revenue Code (0821, 0831, 0841, 0851, 0880, or 0881)	2400 | SV201

For claims with dates of service on or after January 1, 2011, Medicare systems must pass the line item date of service dialysis revenue code lines when the onset of dialysis adjustment is applicable to one or more of the dialysis sessions reported on the claim.

Line Item Date of Service for Revenue Code (0821, 0831, 0841, 0851	*2400 | DTP Segment | D8 qualifier*

In addition to the above claim data, the following payer only codes are required on claims with dates of service on or after January 1, 2011 to calculate the final ESRD PPS rate:

Payer Only Condition Codes (MA, MB, MC, MD, ME, MF)	*2300 | HI segment | BG qualifier*
Payer Only Value Code (79)	*2300 | HI segment | BE qualifier*

Note: These payer only codes above are assigned by the Medicare standard systems and are not submitted on the claim by the provider. Payer only condition codes are only applicable when the appropriate corresponding diagnosis code(s) appears on the claim. See information below in this section on co-morbidy diagnostic categories. The payer only value code 79 represents the dollar amount for services applicable for the calculation in determining an outlier payment.

The following provider data must also be passed to the ESRD PRICER to make provider-specific calculations that determine the final ESRD rate:

Field	**Format**
Actual Geographic Location MSA	X(4)
Actual Geographic Location CBSA	X(5)
Special Wage Index	9(2)V9(4)
Provider Type	X(2)

Special Payment Indicator	X(1)

In addition to the above provider data, the following is required to calculate the final ESRD PPS rate effective January 1, 2011:

Blended Payment Indicator	*X(1)*
Low-Volume Indicator	*X (1)*

ESRD facilities may elect to be reimbursed 100 percent by ESRD PPS no later than November 1, 2010. Facilities that do not elect to be reimbursed 100 percent by the ESRD PPS will be reimbursed by a blended payment rate which is composed of the current basic case-mix adjusted composite rate payment system and the new ESRD PPS.

Blended payment schedule:

Calendar year 2011 – 75 percent of the old payment methodology and 25 percent of new ESRD PPS payment

Calendar year 2012 – 50 percent of the old payment methodology and 50 percent of the new ESRD PPS payment

Calendar year 2013 – 25 percent of the old payment methodology and 75 percent of the new ESRD PPS payment

Calendar year 2014 – 100 percent of the ESRD PPS payment

Based on the claim and provider data shown above, the ESRD PRICER makes adjustments to the facility specific base rate to determine the final composite payment rate. The following factors are used to adjust and make calculations to the final payment rate:

Provider Type	Drug add-on	Budget Neutrality Factor
Patient Age	Patient Height	Patient Weight
Patient BSA	Patient BMI	BSA factor
BMI factor	Condition Code 73 adjustment (if applicable)	Condition Code 74 adjustment (if applicable)

*In addition to the above adjustments, the following adjustments may be applicable to the ESRD PPS base rate for **adult** patient claims with dates of service on or after January 1, 2011:*

Onset of Dialysis	*Patient Co-morbidities*	*Low-Volume ESRD Facility*

Onset of Dialysis:
Providers will receive an adjustment to the ESRD PPS base rate for patients within the first 4 months of dialysis treatment. The provider does not report anything on the claim for this adjustment. The adjustment is determined by the start date of dialysis in the Common Working File as reported on the patient's 2728 form. When the onset of dialysis adjustment is provided, the claim is not entitled to a co-morbidity adjustment or a training add-on adjustment.

Co-morbidity Adjustment Categories
The ESRD PPS will provide adjustments for 6 categories of co-morbidity conditions. Three categories of chronic conditions and 3 categories of acute conditions. ***In the event that more than one of the co-morbidity categories is present on the claim, the claim will be adjusted for the highest paying co-morbidity category.***

Acute Co-morbidity Diagnostic Categories:
The acute co-morbidity categories will be eligible for a payment for the first month reported and the following 3 consecutive months. Acute co-morbidity conditions reported for more than 4 consecutive months will not receive additional payment. In the event that the co-morbidity condition was resolved and later reoccurred, the provider may submit a condition code to indicate the diagnosis is a reoccurrence. The adjustment will be applicable for an additional 4 months.

Acute Categories are:
- *Gastro-intestinal tract bleeding*
- *Bacterial pneumonia*
- *Pericarditis*

Chronic Co-morbidity Diagnostic Categories:
When chronic co-morbidity codes are reported on the claim an adjustment may be made for as long as the chronic condition remains applicable to the patient care provided and is reported on the claim.

Chronic Categories are:
- *Hereditary hemolytic or sickle cell anemia*
- *Monoclonal gammopathy*
- *Myelodysplastic syndrome*

Low-Volume Facilities:

ESRD facilities will receive an adjustment to their ESRD PPS base rate when the facility furnished less than 4,000 treatments in each of the three cost report years preceding the payment year and has not open, closed, or received a new provider number due to a change in ownership during the 3 years preceding the payment year. The ESRD facility must notify their Medicare Contractor if they believe they are eligible for the low-volume adjustment. Contractors must validate the eligibility and update the provider specific file. Pediatric patient claims are not eligible for the low-volume adjustment.

In addition to the above adjustments, the following adjustments may be applicable to the ESRD PPS base rate for ***adult and pediatric*** *patient claims with dates of service on or after January 1, 2011:*

Training Adjustment: *The ESRD PPS provides a training add-on of $33.44 adjusted by the geographic area wage index that accounts for an hour of nursing time for training treatments. The add-on applies to both PD and HD training treatments.*

ESRD PPS Outlier Payments:

Outlier payments may be applied to the payment. ESRD outlier services are the following items and services that are included in the ESRD PPS bundle: (1) ESRD-related drugs and biologicals that were or would have been prior to January 1, 2011, separately billable under Medicare Part B; (2) ESRD-related laboratory tests that were or would have been, prior to January 1, 2011 separately billable under Part B; (3) medical/surgical supplies, including syringes, used to administer ESRD-related drugs that were or would have been prior to January 1, 2011, separately billable under Medicare Part B; and (4) renal dialysis service drugs that were or would have been, prior to January 1, 2011 covered under Medicare Part D. ESRD-related oral only drugs are delayed until January 1, 2014. Services not included in the PPS that remain separately payable are not considered outlier services.

When the ESRD PRICER returns an outlier payment, the standard systems shall display the total applicable outlier payment on the claim with value code 17.

30 - Determination and Publication of Composite Rate

(Rev. 2134, Issued: 01-14-11, Effective: 01-01-11, Implementation: 01-03-11)

30.1 - Publication of Composite Rates

(Rev. 2134, Issued: 01-14-11, Effective: 01-01-11, Implementation: 01-03-11)

The composite rate regulations require CMS to publish composite payment rates in a "Federal Register" notice when CMS incorporates new cost data or wage index. These rates are updated using new program data or revising the payment methodology. Each base rate consists of a labor portion and a nonlabor portion for both hospital and independent renal facilities. When the composite payment rates are updated, a listing of the new composite payment rates is published. These rates are updated and published as needed and are used when issuing a composite payment rate to a new facility or an existing facility.

The CMS notifies FIs when new composite payment rates are issued. An FI, before the effective date of new composite payment rates, is responsible for notifying each ESRD facility of its composite payment rate in writing. At the same time, the FI sends a copy of the notification to CMS Central Office at the following address:

Centers for Medicare & Medicaid Services
Center for Medicare Management
Chronic Care Policy Group
Room: C5-05-27
7500 Security Boulevard
Baltimore, MD 21244-1850

The FI must notify the facility of its payment rate even if the facility's payment rate (i.e. the composite cap of $159.08) does not change. Published composite payment rates stay in effect until CMS announces new payment rates. The issuing of new payment rates includes an effective date for these rates, and the procedures for determining an individual facility's payment rates are in the Medicare Provider Reimbursement Manual (PRM), Part I, §2706.1.

This provision will no longer be applicable for ESRD facilities electing to be reimbursed 100% of the PPS rate on or after January 1, 2011 and for all ESRD facilities on or after January 1, 2014.

40 - Processing Requests for Composite Rate Exceptions

(Rev. 2134, Issued: 01-14-11, Effective: 01-01-11, Implementation: 01-03-11)

Section 153b of the MIPPA creates an ESRD PPS in lieu of the current basic-case-mix composite rate payment system therefore exceptions currently in place no longer apply. No further exception windows will be open effective for ESRD treatments furnished on or after January 1, 2011. For ESRD facilities that have existing exceptions and choose to receive payment under the transition period (discussed in section 20.1 of this manual),those existing exceptions will be recognized for the purpose of the current basic case-mix composite payment rate system portion of the blended payment during the transition. Specifically, existing exception amounts will terminate effective January 1, 2014.

40.85 – Pediatric Payment Model for ESRD PPS

(Rev. 2134, Issued: 01-14-11, Effective: 01-01-11, Implementation: 01-03-11)

The pediatric payment model applies to all dialysis patients that are under the age of 18. The model uses the ESRD PPS base rate applicable to adult dialysis patients which is then adjusted by separate adjusters based on two age groups (<13, 13-17), and dialysis modality (HD, PD).

50.15 - Laboratory Services Included in the ESRD PPS
(Rev. 2134, Issued: 01-14-11, Effective: 01-01-11, Implementation: 01-03-11)

With the implementation of the ESRD PPS, effective for claims with dates of service on or after January 1, 2011, all ESRD-related laboratory services are included in the ESRD PPS base rate..

If the renal dialysis facility needs to report a lab service that was not related to the treatment of ESRD, they must include the modifier AY to indicate the item or service is not for the treatment of ESRD.

ESRD-related lab services that are currently separately paid under the basic case-mix composite rate payment system are considered in the calculation of any applicable outlier payment under the ESRD PPS.

50.25 - Drugs and Biologicals Included in the ESRD PPS
(Rev. 2134, Issued: 01-14-11, Effective: 01-01-11, Implementation: 01-03-11)

With the implementation of the ESRD PPS, effective for claims with dates of service on or after January 1, 2011, all ESRD-related injectable drugs and biologicals and oral equivalents of those injectable drugs and biologicals are included in the ESRD PPS.

If the renal dialysis facility needs to report a drug that was furnished to an ESRD beneficiary that was not related to the treatment of ESRD, they must include the modifier AY to indicate the item or service is not for the treatment of ESRD.

ESRD-related drugs and biologicals that are currently separately paid under the basic case-mix composite rate payment system are considered in the calculation of any applicable outlier payment under the ESRD PPS.

50.3 - Required Information for In-Facility Claims Paid Under the Composite Rate *and the ESRD PPS*
(Rev. 2134, Issued: 01-14-11, Effective: 01-01-11, Implementation: 01-03-11)

The electronic form required for billing ESRD claims is the ANSI X12N 837 Institutional claim transaction. Since the data structure of the 837 transaction is difficult to express in narrative form and to provide assistance to small providers excepted from the electronic claim requirement, the instructions below are given relative to the UB-04 (Form CMS-1450) hardcopy form. A table to crosswalk UB-04 form locators to the 837 transaction is found in Chapter 25, §100.

Type of Bill

Acceptable codes for Medicare are:

721 - Admit Through Discharge Claim - This code is used for a bill encompassing an entire course of outpatient treatment for which the provider expects payment from the payer.

722 - Interim - First Claim - This code is used for the first of an expected series of payment bills for the same course of treatment.

723 - Interim - Continuing Claim - This code is used when a payment bill for the same course of treatment is submitted and further bills are expected to be submitted later.

724 - Interim - Last Claim - This code is used for a payment bill which is the last of a series for this course of treatment. The "Through" date of this bill (FL 6) is the discharge date for this course of treatment.

727 - Replacement of Prior Claim - This code is used when the provider wants to correct (other than late charges) a previously submitted bill. The previously submitted bill needs to be resubmitted in its entirety, changing only the items that need correction. This is the code used for the corrected or "new" bill.

728 - Void/Cancel of a Prior Claim - This code indicates this bill is a cancel-only adjustment of an incorrect bill previously submitted. Cancel-only adjustments should be used only in cases of incorrect provider identification numbers, incorrect HICNs, duplicate payments and some OIG recoveries. For incorrect provider numbers or HICNs, a corrected bill is also submitted using a code 721.

Statement Covers Period (From-Through) - Hospital-based and independent renal dialysis facilities:

The beginning and ending service dates of the period included on this bill. Note: ESRD services are subject to the monthly billing requirements for repetitive services.

Condition Codes

Hospital-based and independent renal facilities complete these items. Note that one of the codes 71-76 is applicable for every bill. Special Program Indicator codes A0-A9 are not required.

Condition Code Structure (only codes affecting Medicare payment/processing are shown).

02 - Condition is Employment Related - Providers enter this code if the patient alleges that the medical condition causing this episode of care is due to environment/events resulting from employment.

04 – **Information Only Bill**- Providers enter this code to indicate the patient is a member of a Medicare Advantage plan.

59 – Non-Primary ESRD Facility – Providers enter this code to indicate that ESRD beneficiary received non-scheduled or emergency dialysis services at a facility other than his/her primary ESRD dialysis facility.

71 - Full Care in Unit - Providers enter this code to indicate the billing is for a patient who received staff-assisted dialysis services in a hospital or renal dialysis facility.

72 - Self-Care in Unit - Providers enter this code to indicate the billing is for a patient who managed his own dialysis in a hospital or renal dialysis facility.

73 - Self-Care in Training - Providers enter this code to indicate the billing is for special dialysis services where a patient and his/her helper (if necessary) were learning to perform dialysis.

76 - Back-up In-facility Dialysis - Providers enter this code to indicate the billing is for a home dialysis patient who received back-up dialysis in a facility.

H3 – Reoccurrence of GI Bleed comorbid category
H4 – Reoccurrence of Pneumonia comorbid category

H5 – Reoccurrence of Pericarditis comorbid Category

Occurrence Codes and Dates

Codes(s) and associated date(s) defining specific events(s) relating to this billing period are shown. Event codes are two alpha-numeric digits, and dates are shown as six numeric digits (MM-DD-YY). When occurrence codes 01-04 and 24 are entered, make sure the entry includes the appropriate value code, if there is another payer involved.

Occurrence and occurrence span codes are mutually exclusive. Occurrence codes have values from 01 through 69 and A0 through L9. Occurrence span codes have values from 70 through 99 and M0 through Z9.

24 - Date Insurance Denied - Code indicates the date of receipt of a denial of coverage by a higher priority payer.

33 - First Day of Medicare Coordination Period for ESRD Beneficiaries Covered by an EGHP - Code indicates the first day of the Medicare coordination period during which Medicare benefits are payable under an EGHP. This is required only for ESRD beneficiaries.

51 – Date of last Kt/V reading. For in-center hemodialysis patients, this is the date of the last reading taken during the billing period. For peritoneal dialysis patients and home

hemodialysis patients, this date may be before the current billing period but should be within 4 months of the claim date of service.

Occurrence Span Code and Dates

Code(s) and associated beginning and ending dates(s) defining a specific event relating to this billing period are shown. Event codes are two alpha-numeric digits and dates are shown numerically as MM-DD-YY.

74 - Noncovered Level of Care - This code is used for repetitive Part B services to show a period of inpatient hospital care or of outpatient surgery during the billing period. Use of this code will not be necessary for ESRD claims with dates of service on or after April 1, 2007 due to the requirement of ESRD line item billing.

Document Control Number (DCN)

Required for all provider types on adjustment requests. (Bill Type/FL=XX7). All providers requesting an adjustment to a previous processed claim insert the DCN of the claims to be adjusted.

Value Codes and Amounts

Code(s) and related dollar amount(s) identify monetary data that are necessary for the processing of this claim. The codes are two alphanumeric digits and each value allows up to nine numeric digits (0000000.00). Negative amounts are not allowed. Whole numbers or non-dollar amounts are right justified to the left of the dollars and cents delimiter. Some values are reported as cents, so refer to specific codes for instructions. If more than one value code is shown for a billing period, show the codes in ascending alphanumeric sequence.

Value Code Structure (Only codes used to bill Medicare are shown.):

06 - Medicare Blood Deductible - Code indicates the amount the patient paid for un-replaced deductible blood.

13 - ESRD Beneficiary in the 30- Month Coordination Period With an EGHP - Code indicates that the amount shown is that portion of a higher priority EGHP payment on behalf of an ESRD beneficiary that applies to covered Medicare charges on this bill. If the provider enters six zeros (0000.00) in the amount field, it is claiming a conditional payment because the EGHP has denied coverage or there has been a substantial delay in its payment. Where the provider received no payment or a reduced payment because of failure to file a proper claim, this is the amount that would have been payable had it filed a proper claim.

37 - Pints of Blood Furnished - Code indicates the total number of pints of blood or units of packed red cells furnished, whether or not replaced. Blood is reported only in terms of

complete pints rounded upwards, e.g., 1 1/4 pints is shown as 2 pints. This entry serves a basis for counting pints towards the blood deductible. Hospital-based and independent renal facilities must complete this item.

38 - Blood Deductible Pints - Code indicates the number of un-replaced deductible pints of blood supplied. If all deductible pints furnished have been replaced, no entry is made. Hospital-based and independent renal facilities must complete this item.

39 - Pints of Blood Replaced - Code indicates the total number of pints of blood donated on the patient's behalf. Where one pint is donated, one pint is replaced. If arrangements have been made for replacement, pints are shown as replaced. Where the provider charges only for the blood processing and administration, i.e., it does not charge a "replacement deposit fee" for un-replaced pints, the blood is considered replaced for purposes of this item. In such cases, all blood charges are shown under the 039x revenue code series, Blood Administration. Hospital-based and independent renal facilities must complete this item.

44 - Amount Provider Agreed To Accept From Primary Payer When This Amount is Less Than Charges But Higher than Payment Received - Code indicates the amount shown is the amount the provider was obligated or required to accept from a primary payer as payment in full when that amount is less than the charges but higher than amount actually received. A Medicare secondary payment is due.

47 - Any Liability Insurance - Code indicates amount shown is that portion from a higher priority liability insurance made on behalf of a Medicare beneficiary that the provider is applying to Medicare covered services on this bill. If six zeros (0000.00) are entered in the amount field, the provider is claiming conditional payment because there has been substantial delay in the other payer's payment.

48 - Hemoglobin Reading - Code indicates the hemoglobin reading taken before the last administration of Erythropoietin (EPO) during this billing cycle. This is usually reported in three positions with a decimal. Use the right of the delimiter for the third digit.

Effective January 1, 2006 the definition of value code 48 is changed to indicate the patient's most recent hemoglobin reading taken before the start of the billing period.

49 - Hematocrit Reading - Code indicates the hematocrit reading taken before the last administration of EPO during this billing cycle. This is usually reported in two positions (a percentage) to the left of the dollar/cents delimiter. If the reading is provided with a decimal, use the position to the right of the delimiter for the third digit.

Effective January 1, 2006 the definition of value code 49 is changed to indicate the patient's most recent hematocrit reading taken before the start of the billing period.

67 - Peritoneal Dialysis - The number of hours of peritoneal dialysis provided during the billing period. Count only the hours spent in the home. Exclude travel time. Report

amount in whole units right-justified to the left of the dollar/cents delimiter. (Round to the nearest whole hour.)

Reporting value code 67 will not be required for claims with dates of service on or after April 1, 2007.

68 - Erythropoietin Units - Code indicates the number of units of administered EPO relating to the billing period and reported in whole units to the left of the dollar/cents delimiter. NOTE: The total amount of EPO injected during the billing period is reported. If there were 12 doses injected, the sum of the units administered for the 12 doses is reported as the value to the left of the dollar/cents delimiter.

Medicare no longer requires value code 68 for claims with dates of service on or after January 1, 2008.

71 - Funding of ESRD Networks - Code indicates the amount of Medicare payment reduction to help fund the ESRD networks. This amount is calculated by the FI and forwarded to CWF. (See §120 for discussion of ESRD networks).

A8 – Weight of Patient – Code indicates the weight of the patient in kilograms. The weight of the patient should be measured after the last dialysis session of the month.

A9 – Height of Patient – Code indicates the height of the patient in centimeters. The height of the patient should be measured during the last dialysis session of the month. This height is as the patient presents.

D5 – Result of last Kt/V reading. For in-center hemodialysis patients this is the last reading taken during the billing period. For peritoneal dialysis patients and home hemodialysis this may be before the current billing period but should be within 4 months of the claim date of service.

Revenue Codes

The revenue code for the appropriate treatment modality under the composite rate is billed (e.g., 0821 for hemodialysis). Services included in the composite rate and related charges must not be shown on the bill separately. Hospitals must maintain a log of these charges in their records for cost apportionment purposes.

Services which are provided but which are not included in the composite rate may be billed as described in sections that address those specific services.

082X - Hemodialysis - Outpatient or Home Dialysis - A waste removal process performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed directly from the blood. Detailed revenue coding is required. Therefore, services may not be summed at the zero level.

0 - General Classification	HEMO/OP OR HOME
1 – Hemodialysis/Composite or other rate	HEMO/COMPOSITE
2 - Home Supplies	HEMO/HOME/SUPPL
3 - Home Equipment	HEMO/HOME/EQUIP
4 - Maintenance 100%	HEMO/HOME/100%
5 - Support Services	HEMO/HOME/SUPSERV
9 - Other Hemodialysis Outpatient	HEMO/HOME/OTHER

083X - Peritoneal Dialysis - Outpatient or Home - A waste removal process performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed indirectly by instilling a special solution into the abdomen using the peritoneal membrane as a filter.

0 - General Classification	PERITONEAL/OP OR HOME
1 - Peritoneal/Composite or other rate	PERTNL/COMPOSITE
2 - Home Supplies	PERTNL/HOME/SUPPL
3 - Home Equipment	PERTNL/HOME/EQUIP
4 - Maintenance 100%	PERTNL/HOME/100%
5 - Support Services	PERTNL/HOME/SUPSERV
9 -Other Peritoneal Dialysis	PERTNL/HOME/OTHER

084X - Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient - A continuous dialysis process performed in an outpatient or home setting, which uses the patient's peritoneal membrane as a dialyzer.

0 - General Classification	CAPD/OP OR HOME
1 - CAPD/Composite or other rate	CAPD/COMPOSITE
2 - Home Supplies	CAPD/HOME/SUPPL
3 - Home Equipment	CAPD/HOME/EQUIP
4 - Maintenance 100%	CAPD/HOME/100%

5 - Support Services	CAPD/HOME/SUPSERV
9 -Other CAPD Dialysis	CAPD/HOME/OTHER

085X - Continuous Cycling Peritoneal Dialysis (CCPD) - Outpatient. - A continuous dialysis process performed in an outpatient or home setting, which uses the patient's peritoneal membrane as a dialyzer.

0 - General Classification	CCPD/OP OR HOME
1 - CCPD/Composite or other rate	CCPD/COMPOSITE
2 - Home Supplies	CCPD/HOME/SUPPL
3 - Home Equipment	CCPD/HOME/EQUIP
4 - Maintenance 100%	CCPD/HOME/100%
5 - Support Services	CCPD/HOME/SUPSERV
9 -Other CCPD Dialysis	CCPD/HOME/OTHER

088X – Miscellaneous Dialysis – Charges for Dialysis services not identified elsewhere.

0 - General Classification	DAILY/MISC
1 – Ultrafiltration	DAILY/ULTRAFILT
2 – Home dialysis aid visit	HOME DIALYSIS AID VISIT
9 -Other misc Dialysis	DAILY/MISC/OTHER

HCPCS/Rates

All hemodialysis claims must include HCPCS 90999 on the line reporting revenue code 082x.

Modifiers

Modifiers are required *with* ESRD Billing for *reporting the* adequacy of *dialysis, presence of infection and the vascular access. For information on modifiers required for these quality measures see* 50.9 of this chapter.

For information on reporting the GS modifier for reporting a dosage reduction of epoetin alfa or darbepoetin alfa, see sections 60.4 and 60.7 of this chapter.

For information on reporting the AY modifier for services not related to the treatment of ESRD, see sections *60.2.1.1 – Separately Billable ESRD Drugs and 60.1 - Lab Services*

Service Date

Report the line item date of service for each dialysis session and each separately payable item or service.

Service Units

Hospital-based and independent renal facilities must complete this item. The entries quantify services by revenue category, e.g., number of dialysis treatments. Units are defined as follows:

0634 - Erythropoietin (EPO) - Administrations, i.e., the number of times an injection of less than 10,000 units of EPO was administered. For claims with dates of service on or after January 1, 2008, facilities use the units field as a multiplier of the dosage description in the HCPCS to arrive at the dosage amount per administration.

0635 - Erythropoietin (EPO) - Administrations, i.e., the number of times an injection of 10,000 units or more of EPO was administered. For claims with dates of service on or after January 1, 2008, facilities use the units field as a multiplier of the dosage description in the HCPCS to arrive at the dosage amount per administration.

082X - (Hemodialysis) – Sessions

083X - (Peritoneal) – Sessions

084X - (CAPD) - Days covered by the bill

085X - (CCPD) - Days covered by the bill

Effective April 1, 2007, the implementation of ESRD line item billing requires that each dialysis session be billed on a separate line. As a result, claims with dates of service on or after April 1, 2007 should not report units greater than 1 for each dialysis revenue code line billed on the claim.

Total Charges

Hospital-based and independent renal facilities must complete this item. Hospital-based facilities must show their customary charges that correspond to the appropriate revenue code. They must not enter their composite or the EPO` rate as their charge. Independent facilities may enter their composite and/or EPO rates.

Neither revenue codes nor charges for services included in the composite rate may be billed separately (see §90.3 for a description). Hospitals must maintain a log of these charges in their records for cost apportionment purposes.

Services which are provided but which are not included in the composite rate may be billed as described in sections that address those specific services.

The last revenue code entered in as 000l represents the total of all charges billed.

Principal Diagnosis Code

Hospital-based and independent renal facilities must complete this item and it should include a diagnosis of end stage renal disease.

Other Diagnosis Code(s)
For claims with dates of service on or after January 1, 2011 renal dialysis facilities report the appropriate diagnosis code(s) for co-morbidity conditions eligible for an adjustment.

NOTE: Information regarding the form locator numbers that correspond to these data element names and a table to crosswalk UB-04 form locators to the 837 transaction is found in Chapter 25.

50.8 - Training and Retraining

(Rev. 2134, Issued: 01-14-11, Effective: 01-01-11, Implementation: 01-03-11)

See the Medicare Benefit Policy Manual, Chapter 11, for coverage rules for dialysis training.

Training services and supplies that are covered under the composite rate include personnel services, dialysis supplies and parenteral items used in dialysis, written training manuals, material and laboratory tests. The facility is reimbursed an add-on amount to their composite rate and the amount is dependent on the type of dialysis, as shown below:

0821	Composite Rate	Plus	$20.00
0831	Composite Rate	Plus	$20.00
0841	Composite Rate	Plus	$12.00
0851	Composite Rate	Plus	$20.00

Training

For intermittent peritoneal dialysis (IPD), continuous cycling peritoneal dialysis (CCPD) and hemodialysis training:

> The facility's composite rate (exclusive of any approved exception amount) plus $20 per training session, furnished up to three times per week. A facility is not reimbursed for more than three IPD or for hemodialysis training treatments in a single week, of for a total duration longer than 3 months, unless it has received an exception in accordance with §40 of this chapter. A maximum of 15 CCPD training sessions are reimbursable.

For continuous ambulatory peritoneal dialysis (CAPD):

> The facility's composite rate (exclusive of any approved exception amount) plus $12 per training session. Only one CAPD training session per day is reimbursable, up to a maximum of 15.

Retraining

A. General - Occasionally, it is necessary to furnish additional training to an ESRD self-dialysis beneficiary after the initial training course is completed. Retraining sessions are paid under the following conditions:

- The patient changes from one mode of dialysis to another, e.g., from hemodialysis to CAPD;
- The patient's home dialysis equipment changes;
- The patient's dialysis setting changes;
- The patient's dialysis partner changes; or
- The patient's medical condition changes e.g., temporary memory loss due to stroke, physical impairment.

The patient must continue to be an appropriate patient for self-dialysis.

B. Payment Rates - Retraining sessions are reimbursed at the same rate as the facility's training rate.

C. Duplicate Payments - No composite rate payment is made for a home dialysis treatment furnished on the same day as a retraining session. In the case of a CAPD patient, the facility's equivalent CAPD daily rate is not paid on the day(s) of retraining.

EXAMPLE: A CAPD patient dialyzes at home Monday and Tuesday. On Wednesday he attends a retraining session at his facility. Thursday through Sunday he dialyzes at home. The facility's composite rate is $130 per treatment. The Part B deductible is met. For that week the facility's payment is:

80 percent of:

> CAPD weekly rate = 3 X 130 = $390
>
> CAPD daily rate = $390 ÷ 7 = $55.71
>
> CAPD training rate = $130 + $12 = $142

6 X 55.71 = $334.26

+ $142

$476.26

Therefore, for the week Monday - Sunday, payment is 80 percent X $476.26 = $381.01

NOTE: Often, services furnished to a CAPD patient who has already completed a course of training are home support services, and not retraining services. Reviewing the CAPD patient's technique and instructing him/her in any corrections or refinements in technique is a support service; and, therefore, is not covered as a retraining service.

ESRD PPS claims with dates of service on or after January 1, 2011 billing for dialysis training sessions will receive a training add-on of $33.44 adjusted by the geographic area wage index that accounts for an hour of nursing time for training treatments. The add-on adjustment applies to both PD and HD training treatments.

50.9 - Coding for Adequacy of Dialysis, Vascular Access and Infection

(Rev. 2134, Issued: 01-14-11, Effective: 01-01-11, Implementation: 01-03-11)

A. Reporting the Urea Reduction Ratio(URR) for ESRD Hemodialysis Claims

All hemodialysis claims must indicate the most recent Urea Reduction Ratio (URR) for the dialysis patient. Code all claims using HCPCS code 90999 along with the appropriate G modifier listed in section B.

Claims for dialysis treatments must include the adequacy of hemodialysis data as measured by URR. Dialysis facilities must monitor the adequacy of dialysis treatments monthly for facility patients. Home hemodialysis and peritoneal dialysis patients may be monitored less frequently, but not less than quarterly. If a home hemodialysis patient is not monitored during a month, the last, most recent URR for the dialysis patient must be reported.

HCPCS code 90999 (unlisted dialysis procedure, inpatient or outpatient) must be reported in field location 44 for all bill types 72X. The appropriate G-modifier in field location 44 (HCPCS/RATES) is used, for patients that received seven or more dialysis treatments in a month. Continue to report revenue codes 0820, 0821, 0825, and 0829 in field location 43.

G1 - Most recent URR of less than 60%
G2 - Most recent URR of 60% to 64.9%
G3 - Most recent URR of 65% to 69.9%
G4 - Most recent URR of 70% to 74.9%
G5 - Most recent URR of 75% or greater

For patients that have received dialysis 6 days or less in a month, facilities use the following modifier:

G6 - ESRD patient for whom less than seven dialysis sessions have been provided in a month.

For services beginning January 1, 2003, and after, if the modifier is not present, FIs must return the claim to the provider for the appropriate modifier. Effective April, 2007 due to the requirement of line item billing, at least one revenue code line for hemodialysis on the claim must contain one of the URR modifiers shown above. The URR modifier is not required on every hemodialysis line on the claim.

The techniques to be used to draw the pre- and post-dialysis blood urea Nitrogen samples are listed in the National Kidney Foundation Dialysis Outcomes Quality Initiative Clinical Practice Guidelines for Hemodialysis Adequacy, Guideline 8, Acceptable Methods for BUN sampling, New York, National Kidney Foundation, 2000, pp.53-60.

B. Reporting the Vascular Access for ESRD Hemodialysis Claims

ESRD claims for hemodialysis with dates of service on or after July 1, 2010 must indicate the type of vascular access used for the delivery of the hemodialysis at the last hemodialysis session of the month. One of the following codes is required to be reported on the latest line item date of service billing for hemodialysis revenue code 0821. It may be reported on all revenue code 0821 lines at the discretion of the provider.

Modifier V5 - Any Vascular Catheter (alone or with any other vascular access),
Modifier V6 - Arteriovenous Graft (or other Vascular Access not including a vascular catheter)
Modifier V7 - Arteriovenous Fistula Only (in use with two needles)

C. Reporting the Kt/V for ALL ESRD Claims

All ESRD claims with dates of service on or after July 1, 2010 must indicate the applicable Kt/V reading for the dialysis patient. The reading result and the date of the reading must be reported on the claim using the following claim codes:

Value Code D5 – Result of last Kt/V reading. For in-center hemodialysis patients this is the last reading taken during the billing period. For peritoneal dialysis patients and home hemodialysis this may be before the current billing period but should be within 4 months of the claim date of service.

This code is effective and required on all ESRD claims with dates of service on or after July 1, 2010. In the event that no Kt/V reading was performed providers must report the D5 with a value of 9.99.

Occurrence Code 51 – Date of last Kt/V reading. For in-center hemodialysis patients, this is the date of the last reading taken during the billing period. For peritoneal dialysis patients and home hemodialysis patients, this date may be before the current billing

period but should be within 4 months of the claim date of service. This code is effective for ESRD claims with dates of service on or after July 1, 2010. If no Kt/V reading was performed do not report this code.

D. Reporting of Infection for ALL ESRD Claims

All ESRD claims with dates of service on or after July 1, 2010 must indicate on the claim if an infection was present at the time of treatment. Claims must report on each dialysis revenue code line one of the following codes:

Modifier V8: Dialysis access-related infection present (documented and treated) during the billing month. Reportable dialysis access-related infection is limited to peritonitis for peritoneal dialysis patients or bacteremia for hemodialysis patients. Facilities must report any peritonitis related to a peritoneal dialysis catheter, and any bacteremia related to hemodialysis access (including arteriovenous fistula, arteriovenous graft, or vascular catheter) if identified during the billing month. For individuals that receive different modalities of dialysis during the billing month and an infection is identified, the V8 code should only be indicated on the claim for the patient's primary dialysis modality at the time the infection was first suspected. Non-access related infections should not be coded as V8. If no dialysis-access related infection is present during the billing month by this definition, providers should instead report modifier V9.

Modifier V9: No dialysis-access related infection, as defined for modifier V8, present during the billing month. Dialysis access-related infection, defined as peritonitis for peritoneal dialysis patients or bacteremia for hemodialysis patients must be reported using modifier V8. Providers must report any peritonitis related to a peritoneal dialysis catheter, and any bacteremia related to hemodialysis access (including arteriovenous fistula, arteriovenous graft, or vascular catheter) using modifier V8.

ESRD facilities may report the HCPCS 90999 Unlisted Dialysis Procedure Inpatient or Outpatient to report the above modifiers.

60.1 - Lab Services

(Rev. 2134, Issued: 01-14-11, Effective: 01-01-11, Implementation: 01-03-11)

See the Medicare Benefit Policy Manual, Chapter 11, for a description of lab services included in the composite rate.

Independent laboratories and independent dialysis facilities with the appropriate clinical laboratory certification in accordance with CLIA may be paid for ESRD clinical laboratory tests that are separately billable. The laboratories and independent dialysis facilities are paid for separately billable clinical laboratory tests according to the Medicare laboratory fee schedule for independent laboratories. (See Chapter 16, section 40.3 for details on Part B hospital billing rules for laboratory services and Chapter 16, section 40.6 for details on ESRD billing.)

Hospital-based laboratories providing separately billable laboratory services to dialysis patients of the hospital's dialysis facility or another dialysis facility bill and are paid in accordance with the hospital outpatient laboratory provisions in Chapter 16, section 40.3. If the ESRD patient also receives other hospital outpatient services on the same day as a specimen collection and/or laboratory test, then the patient is considered to be a registered hospital outpatient and cannot be considered to be a non-patient on that day for purposes of the specimen collection and laboratory test. When the patient does not also receive hospital outpatient services on the same day as the specimen collection and/or laboratory test, then the hospital may choose to register the beneficiary as an outpatient for the specimen collection or bill for these services as non-patient on the 14x bill type.

Clinical laboratory tests are performed individually. Automated profiles and application of the "50 percent rule" can be found in Chapter 16 of this manual.

A specimen collection fee determined by CMS (as of this writing, up to $3.00) will be allowed for ESRD Method II billing only in the following circumstances:

- Drawing a blood sample through venipuncture (i.e., inserting into a vein a needle with a syringe or vacutainer to draw the specimen).

- Collecting a urine sample by catheterization.

Laboratory tests for Hemodialysis, Intermittent Peritoneal Dialysis (IPD), Continuous Cycling Peritoneal Dialysis (CCPD), and Hemofiltration (as specified in the Medicare Benefit Policy Manual Pub. 100-02, Chapter 11, Section 30.2) are usually performed for dialysis patients and are routinely covered at the frequency specified in the absence of indications to the contrary, i.e., no documentation of medical necessity is required other than knowledge of the patient's status as an ESRD beneficiary. When any of these tests is performed at a frequency greater than that specified, the additional tests are separately billable and are covered only if they are medically justified by accompanying documentation. A diagnosis of ESRD alone is not sufficient medical evidence to warrant coverage of the additional tests. The nature of the illness or injury (diagnosis, complaint, or symptom) requiring the performance of the test(s) must be present on the claim. Such information must be furnished using the ICD-9-CM coding system.

Effective January 1, 2011, section 153b of the MIPPA requires that all ESRD-related lab tests must be billed by the renal dialysis facility whether provided directly or under arrangements with an independent lab. When lab services are billed by providers other than the ESRD facility and the lab furnished is designated as a lab that is included in the ESRD PPS (ESRD-related), the claim will be rejected or denied. In the event that an ESRD-related lab service was furnished to an ESRD beneficiary for reasons other than for the treatment of ESRD, the provider may submit a claim for separate payment using modifier AY.

60.2 - Drugs Furnished in Dialysis Facilities

(Rev. 2134, Issued: 01-14-11, Effective: 01-01-11, Implementation: 01-03-11)

There are some drugs that are not covered under the composite rate, but that may be medically necessary for some patients receiving dialysis. See the Medicare Benefit Policy Manual, Pub.100-02, Chapter 11, Section 30.4.1 for a description of drugs that are part of the composite rate and when other drugs may be covered.

Except for EPO and Darbepoetin Alfa (Aranesp), (see §60.4), drugs and biologicals, such as blood, may be covered in the home dialysis setting only if the "incident to a physician's services" criteria are met (i.e., it is not covered under the composite rate). Normally, a physician is not in the patient's home when the drugs or biologicals are administered, and therefore, drugs and biologicals generally are not paid in the home setting.

Effective January 1, 2011, section 153b of the MIPPA requires that all ESRD-related drugs and biologicals are included in the ESRD PPS and must be billed by the renal dialysis facility.

60.2.1.1 – Separately Billable ESRD Drugs

(Rev. 2134, Issued: 01-14-11, Effective: 01-01-11, Implementation: 01-03-11)

The following categories of drugs (including but not limited to) are separately billable when used to treat the patient's renal condition:

- Antibiotics;
- Analgesics;
- Anabolics;
- Hematinics;
- Muscle relaxants;
- Sedatives;
- Tranquilizers; and
- Thrombolytics: used to declot central venous catheters.

NOTE: Erythropoietin replacement therapies are separately billable and paid at established rates through appropriate billing methodology: Epotein Alfa (EPO) §60.4 and Darbepoetin Alfa (Aranesp) §60.7.

These separately billable drugs may only be billed by an ESRD facility if they are actually administered in the facility by the facility staff. Staff time used to administer separately billable drugs is covered under the composite rate and may not be billed separately. However, the supplies used to administer these drugs may be billed in addition to the composite rate.

Effective January 1, 2011, section 153b of the MIPPA requires that all ESRD-related drugs and biologicals be billed by the renal dialysis facility. When a drug or biological

is billed by providers other than the ESRD facility and the drug or biological furnished is designated as a drug or biological that is included in the ESRD PPS (ESRD-related), the claim will be rejected or denied. In the event that an ESRD-related drug or biological was furnished to an ESRD beneficiary for reasons other than for the treatment of ESRD, the provider may submit a claim for separate payment using modifier AY.

All drugs reported on the renal dialysis facility claim are considered included in the ESRD PPS. The list of drugs and biologicals for consolidated billing are designated as always ESRD-related and therefore not allowing separate payment to be made to ESRD facilities. Other drugs and biologicals may be considered separately payable to the dialysis facility if the drug was not for the treatment of ESRD. The facility must include the modifier AY to indicate it was not for the treatment of ESRD.

60.2.1.2 –Facilities Billing for ESRD Drugs and Biologicals Equivalent to Injectable Drugs

(Rev. 2134, Issued: 01-14-11, Effective: 01-01-11, Implementation: 01-03-11)

The ESRD PPS includes some drugs and biologicals that are currently paid under Medicare D when these drugs can be used as equivalents to ESRD-related injectable drugs and biologicals. These drugs may be reported on the renal dialysis facility claim for consideration of outlier payments. For the ESRD-related drugs and biologicals that do not have an assigned HCPCS, effective for dates of services on or after January 1, 2011, ESRD facilities should bill using revenue code 0250 and report the national drug code (NDC). The NDC is reported on the 837i claim transaction in loop 2410 line 03.

CMS will price these drugs based on a plan comparison for consideration in the outlier payment. CMS will maintain a list of these drug categories by NDC. Payment includes a mean dispensing fee of $1.73. This amount will be applied to each NDC included on the monthly claim. We limit 1 dispensing fee per NDC per month. Providers should report the quantity in the smallest available unit. This is necessary because Medicare is using the mean per unit cost in calculating the outlier. For example, if the provider reports NDC 00054312041 Calcitriol 1 mcg/ml oral solution (15/ml/bottle) and uses the full 15 ml bottle, the quantity is reported as 15, not 1. This allows for the most accurate calculation for the outlier.

60.2.2 - Drug Payment Amounts for Facilities

(Rev. 2134, Issued: 01-14-11, Effective: 01-01-11, Implementation: 01-03-11)

Hospital-based facilities are paid at cost with applicable coinsurance and deductibles. Independent facilities are paid based on the lower of billed charges or 95 percent AWP for the calendar year 2004: coinsurance and deductibles are applied to billed charges. Effective January 1, 2006, both hospital-based and independent ESRD facilities will be paid ASP+6% for all separately billable drugs except vaccines. See Chapter 17 for a complete description of drug pricing.

Effective for claims with dates of service on or after January 1, 2011 all ESRD-related drugs and biologicals are reimbursed under the ESRD PPS payment amount.

60.3 - Blood and Blood Services Furnished in Hospital Based and Independent Dialysis Facilities

(Rev. 2134, Issued: 01-14-11, Effective: 01-01-11, Implementation: 01-03-11)

Facility staff time used to perform any service in the dialysis unit, including time to administer blood, is included in the composite rate. However, the following may be paid in addition to the composite rate.

- Blood;
- Supplies used to administer blood; and
- Blood processing fees (e.g. blood typing and cross-matching) that are charged by the blood supplier or lb.

Hospital-based facilities - Payment is made on a reasonable cost basis in the same way as for any other Medicare beneficiary receiving blood on an outpatient basis. In determining the reasonable cost for blood, FIs consider the charges for blood from independent blood banks.

Independent dialysis facilities - Payment is made at the lower of the actual charge on the bill or a reasonable charge that the FI determines. In establishing the reasonable charge, FIs consider price lists of independent blood banks (e.g., Red Cross or hospital) that offer services to providers in the area. Also, the carrier allowable charges are considered where available.

Billing Entries related to blood - HCPCS codes and related charges are reported by both hospital-based and independent renal facilities. If HCPCS codes are sufficient to describe the services provided by blood banks in the contractors area, the carrier should establish reasonable charge amounts for the codes and make payments to facilities based on the lower of the billed charge or the reasonable charge amounts.

In some areas, blood banks group a number of services into one charge. For example, they may have one charge covering washed cells with a crossmatch. There is one HCPCS code for washed red blood cells, and there are others for typing and crossmatching. Facilities should use a combination of the available codes to reflect the one charge by the blood bank. However, if this skews the payment for independent facilities, the contractor should assign a local code for the combination of services.

For supplies, facilities use revenue code 0270. Contractors establish local codes for blood administration sets and filters and set reasonable charge amounts for independent facilities.

Contractors should report local codes, along with the definition and billing frequency, by the 15th of the month following the end of each quarter to:

Centers for Medicare & Medicaid Services
Center for Medicare Management
Chronic Care Policy Group
Room: C5-05-27
Mail Stop C4-10-07
7500 Security Blvd.
Baltimore MD 21244-1850

Also, send a copy to the HCPCS Coordinator in your RO.

NOTE: All unapproved local procedure and modifier codes must be deleted by October 16, 2002. All approved HCPCS Level III local codes and modifiers must be deleted by December 31, 2003. For information on obtaining temporary national codes to replace any essential local codes, see transmittal AB-02-005.

Blood and blood products remain separately payable under the ESRD PPS.

60.4.3 - Payment Amount for Epoetin Alfa (EPO)

(Rev. 2134, Issued: 01-14-11, Effective: 01-01-11, Implementation: 01-03-11)

Dates of service prior to January 1, 2005, the FI pays the facility $10 per 1,000 units of EPO administered, rounded to the nearest 100 units (i.e., $1.00 per 100 units). Effective January 1, 2005, EPO will be paid based on the ASP Pricing File. Also effective January 1, 2005, the cost of supplies to administer EPO may be billed to the FI. HCPCS A4657 and Revenue Code 270 should be used to capture the charges for syringes used in the administration of EPO. Where EPO is furnished by a supplier that is not a facility, the DMERC pays at the same rate.

Physician payment is calculated through the drug payment methodology described in Chapter 17 of the Claims Processing Manual.

EXAMPLE: The billing period is 2/1/94 - 2/28/94.

The facility provides the following:

Date	**Units**	**Date**	**Units**
2/1	3000	2/15	2500
2/4	3000	2/18	2500
2/6	3000	2/20	2560
2/8	3000	2/22	2500
2/11	2500	2/25	2000
2/13	2500	2/27	2000

Total 31,060 units

For value code 68, the facility enters 31,060. The 31,100 are used to determine the rate payable. This is 31,060 rounded to the nearest 100 units. The amount payable is 31.1 x $10 =$311.00. In their systems, FIs have the option of setting up payment of $1.00 per 100 units. Effective January 1, 2005, EPO will be paid based on the ASP Pricing File.

Effective January 1, 2008, payment is calculated on a renal dialysis facility claim at the line level by multiplying the rate from the ASP pricing file by the number of units reported on the line billing for EPO.

EXAMPLE: 311 x $1.00 = $311.00

If an ESRD beneficiary requires 10,000 units or more of EPO per administration, special documentation must be made in the medical records. It must consist of a narrative report that addresses the following:

- Iron deficiency. Most patients need supplemental iron therapy while being treated, even if they do not start out iron deficient;
- Concomitant conditions such as infection, inflammation, or malignancy. These conditions must be addressed to assure that EPO has maximum effect;
- Unrecognized blood loss. Patients with kidney disease and anemia may easily have chronic blood loss (usually gastrointestinal) as a major cause of anemia. In those circumstances, EPO is limited in effectiveness;
- Concomitant hemolysis, bone morrow dysplasia, or refractory anemia for a reason other than renal disease, e.g., aluminum toxicity;
- Folic acid or vitamin B12 deficiencies;
- Circumstances in which the bone morrow is replaced with other tissue, e.g., malignancy or osteitis fibrosa cystica; and

Patient's weight, the current dose required, a historical record of the amount that has been given, and the hematocrit response to date.

Payment for ESRD-related EPO is included in the ESRD PPS for claims with dates of service on or after January 1, 2011.

60.4.3.1 - Payment for Epoetin Alfa (EPO) in Other Settings

(Rev. 2134, Issued: 01-14-11, Effective: 01-01-11, Implementation: 01-03-11)

In the hospital inpatient setting, payment under Part A is included in the DRG.

In the hospital inpatient setting, payment under Part B is made on bill type 12x. Hospitals report the drug units based on the units defined in the HCPCS description. Hospitals do not report value code 68 for units of EPO. For dates of service prior to April 1, 2006, report EPO under revenue code 0636. For dates of service from April 1, 2006 report EPO under the respective revenue code 0634 for EPO less than 10,000 units and revenue code 0635 for EPO over 10,000 units. Payment will be based on the ASP Pricing File. .

In a skilled nursing facility (SNF), payment for EPO covered under the Part B EPO benefit is not included in the prospective payment rate for the resident's Medicare-covered SNF stay.

In a hospice, payment is included in the hospice per diem rate.

For a service furnished by a physician or incident to a physician's service, payment is made to the physician by the carrier in accordance with the rules for 'incident to" services. When EPO is administered in the renal facility, the service is not an "incident to" service and not under the "incident to" provision.

With the implementation of the ESRD PPS, ESRD-related EPO is included in ESRD PPS payment amount and is not separately payable on Part B claims with dates of service on or after January 1, 2011 for other providers with the exception of a hospital billing for an emergency or unscheduled dialysis session..

60.6 - Vaccines Furnished to ESRD Patients

(Rev. 2134, Issued: 01-14-11, Effective: 01-01-11, Implementation: 01-03-11)

The Medicare program covers hepatitis B, influenza virus and Pneumococcal pneumonia virus (PPV) vaccines and their administration when furnished to eligible beneficiaries in accordance with coverage rules. Payment may be made for both the vaccine and the administration. The costs associated with the syringe and supplies are included in the administration fee: HCPCS code A4657 should not be billed for these vaccines.

Vaccines and their administration are reported using separate codes. See Chapter 18 of this manual for the codes required for billing vaccines and the administration of the vaccine.

Payment for vaccine administration (PPV, Influenza Virus, and Hepatitis B Virus) to freestanding RDFs is based on the Medicare Physician Fee Schedule (MPFS) according to the rate in the MPFS associated with code 90782 for services provided prior to March 1, 2003 and code 90471 for services provided March 1, 2005 and later and on reasonable cost for provider-based RDFs.

Vaccines remain separately payable under the ESRD PPS.

60.7.3 - Payment Amount for Darbepoetin Alfa (Aranesp)

(Rev. 2134, Issued: 01-14-11, Effective: 01-01-11, Implementation: 01-03-11)

For Method I patients, the FI pays the facility per one mcg of Aranesp administered, in accordance with the MMA Drug Payment Limits Pricing File rounded up to the next highest whole mcg. Effective January 1, 2005, Aranesp will be paid based on the ASP Pricing File. Effective January 1, 2005, the cost of supplies to administer Aranesp may be billed to the FI. HCPCS A4657 and Revenue Code 270 should be used to capture the charges for syringes used in the administration of Aranesp.

Physician payment is calculated through the drug payment methodology described in Chapter 17, of the Claims Processing Manual.

The coinsurance and deductible are based on the Medicare allowance payable, not on the provider's charges. The provider may not charge the beneficiary more than 20 percent of the Medicare Aranesp allowance. This rule applies to independent and hospital based renal facilities.

Payment for ESRD-related Aranesp is included in the ESRD PPS for claims with dates of service on or after January 1, 2011.

60.7.3.1 - Payment for Darbepoetin Alfa (Aranesp) in Other Settings

(Rev. 2134, Issued: 01-14-11, Effective: 01-01-11, Implementation: 01-03-11)

In the hospital inpatient setting, payment under Part A for Aranesp is included in the DRG.

In the hospital inpatient setting, payment under Part B is made on bill type 12x when billed with revenue code 0636. The total number of units as a multiple of 1mcg is placed in the unit field. Reimbursement is based on the payment allowance limit for Medicare Part B drugs as found in the ASP pricing file.

In a skilled nursing facility (SNF), payment for Aranesp covered under the Part B EPO benefit is not included in the prospective payment rate for the resident's Medicare-covered SNF stay.

In a hospice, payment is included in the hospice per diem rate.

For a service furnished by a physician or incident to a physician's service, payment is made to the physician by the carrier in accordance with the rules for 'incident to" services. When Aranesp is administered in the renal facility, the service is not an "incident to" service and not under the "incident to" provision.

With the implementation of the ESRD PPS, ESRD-related Aranesp is included in the ESRD PPS payment amount and is not separately payable on Part B claims with dates of service on or after January 1,2011 for other providers, with the exception of a hospital billing for an emergency or unscheduled dialysis session.

70 - Payment for Home Dialysis

(Rev. 2134, Issued: 01-14-11, Effective: 01-01-11, Implementation: 01-03-11)

Home dialysis is dialysis performed by an appropriately trained dialysis patient at home. Hemodialysis, CCPD, IPD and CAPD may be performed at home. For all dialysis services furnished by an ESRD facility, the facility must accept assignment, and only the facility may be paid by the Medicare program. Method II suppliers can receive payment for patients selecting Method II. The Method II supplier must accept assignment. Method II suppliers receive payment for supplies and equipment only.

For purposes of home dialysis, a skilled nursing facility (SNF) may qualify as a beneficiary's home. The services are excluded from SNF consolidated billing for its inpatients. The home dialysis services are billed either by the ESRD facility or the supplier depending on the Method selection made by the beneficiary.

With the implementation of the ESRD PPS, payment for all home dialysis services furnished to the ESRD beneficiary is made to a renal dialysis facility whether services were provided directly or under arrangements.

70.1 - Method Selection for Home Dialysis Payment

(Rev. 2134, Issued: 01-14-11, Effective: 01-01-11, Implementation: 01-03-11)

Medicare beneficiaries dialyzing at home can choose between two methods for Medicare program payment for care (exclusive of physician services), Method I or Method II as described below in §70.2.

When an ESRD beneficiary begins a course of home dialysis, he or she fills out the Form CMS-382, "ESRD Beneficiary Selection," to choose whether he or she wants to use Method I or Method II to obtain home dialysis equipment and supplies. Refer to http://www.cms.hhs.gov/cmsforms/downloads/cms382.pdf for a copy of the ESRD Method Selection Form CMS-382, and the related instructions.

The beneficiary and or provider must:

- Furnish the information requested in items 1-6;
- Check only one block in items 7-9; and
- Enter the effective date at the bottom of item 7

The beneficiary must sign and date in items 11 and 12.

The facility sends the completed form to the FI. When the FI receives the correctly completed Form CMS-382, it must enter the beneficiary's choice into the common working file (CWF) within 30 days of receipt. The format is in Chapter 27. For method II selections, the FI must follow-up every 30 days until the method selection has been correctly entered.

If a claim is received by the Intermediary on behalf of a beneficiary for whom an initial election is not recorded on CWF, CWF informs the FI to return the claim to the provider.

The provider must submit a copy of the completed Form CMS-382 prior to resubmitting the claim.

If a claim is received by the Intermediary on behalf of a beneficiary for whom Method I has been selected, CWF informs the FI to deny the claim.

DMERCs deny Method II claims where there is no method selection on file at CWF.

Section 153b of the Medicare Improvements for Patients and Providers Act (MIPPA) eliminates method II home dialysis claims. All home dialysis claims must be billed by a renal dialysis facility and paid under the ESRD PPS. As a result, the submission of the CMS-382 form to the Medicare contractors is no longer required for home dialysis patients on or after January 1, 2011.

Attachment 1: PRICER File Layout.

```
*****************************************************************
* Note: All items defined as numeric should contain a number even*
* if it is zero.  Newly defined return codes are not used when   *
* bills prior to 2011 are processed.                             *
*                                                                *
*****************************************************************
*   ***** Possible Return Codes From CALCULTE Subtoutine *****   *
*   ****  PPS-RTC 00-49 = Bill Payment Information Codes         *
*   **  OLD Return code    effective 4/1/2005 - 12/31/2010       *
*          00 = ESRD PPS Payment calculated                      *
*                                                                *
*   **  NEW Return codes   effective 1/1/2011                    *
*          02 = no adjustments                                   *
*          03 = w/outlier                                        *
*          04 = w/acute comorbid                                 *
*          05 = w/chronic comorbid                               *
*          06 = w/acute comorbid, outlier                        *
*          07 = w/chronic comorbid, outlier                      *
*          08 = w/onset                                          *
*          09 = w/onset, outlier                                 *
*          10 = w/low volume                                     *
*          11 = w/training                                       *
*          12 = w/low volume, training                           *
*          13 = w/multiple adjustments                           *
```

```
*          14 = w/pediatric                                          *
*          15 = w/pediatric, training                                *
*          16 = w/pediatric, outlier                                 *
*          17 = w/pediatric, outlier, training                       *
*          18 = w/acute comorbid, outlier, low volume                *
*          19 = w/acute comorbid, outlier, low volume, training      *
*          20 = w/acute comorbid, low volume                         *
*          21 = w/acute comorbid, low volume, training               *
*          22 = w/acute comorbid, training                           *
*          23 = w/chronic comorbid, outlier, low volume              *
*          24 = w/chronic comorbid, outlier, low volume, training    *
*          25 = w/chronic comorbid, low volume                       *
*          26 = w/chronic comorbid, low volume, training             *
*          27 = w/chronic comorbid, training                         *
*          28 = w/outlier, low volume                                *
*          29 = w/outlier, low volume, training                      *
*          30 = w/onset, outlier, low volume                         *
*          31 = w/low BMI                                            *
*                                                                    *
*    **    PPS-RTC 50-99 = Why the bill was NOT paid                 *
*                                                                    *
*          52 = Provider type NOT = '40' OR '41'                     *
*          53 = Special payment indicator NOT = '1' OR blank         *
*          54 = Date of Birth  NOT numeric OR = ZERO                 *
*          55 = Patient Weight NOT numeric OR = ZERO                 *
```

```
*          56 = Patient Height NOT numeric OR = ZERO             *
*          57 = Revenue Center Code NOT in range                 *
*          58 = Condition Code NOT = '73' OR '74' OR blank       *
*          71 = Exceeds Maximum Height allowance                 *
*          72 = Exceeds Maximum Weight allowance                 *
*          73 = Claim-Num-Dial-Session NOT numeric OR = ZERO     *
*          74 = Line-Item-Svc-Date NOT numeric OR = ZERO         *
*          75 = Dial-Start-Date NOT numeric  OR = ZERO           *
*          76 = Tot-Outlier-Pmt NOT numeric                      *
*          81 = Comorbid-CWF-Return-code NOT valid               *
*                                                                *
*                                                                *
*   ***** Possible Return Codes From DRIVER Subtoutine *****     *
*                                                                *
*   ****  PPS-RTC 00-49 = Bill Payment Information Codes         *
*   **  OLD Return code    effective 4/1/2005 - 12/31/2010       *
*          01 = ESRD facility rate > ZERO                        *
*                                                                *
*   **    PPS-RTC 50-99 = Why the bill was NOT paid             *
*                                                                *
*          50 = ESRD facility rate not numeric                   *
*MAINFRAME 60 = CBSA wage adjusted rate record not found         *
*          98 = Claim through date before 04/01/05 or not numeric*
******************************************************************
111510wt
```

Attachment 2: Common Working File Screen Example – ESRD Beneficiary Acute Cormobid Conditions

Most Current Period

MA: GI Bleed	MB: Pneumonia	MC: Pericarditis
Onset Date:	Onset Date:	Onset Date:
From Thru PI	From Thru PI	From Thru PI
From Thru PI	From Thru PI	From Thru PI
From Thru PI	From Thru PI	From Thru PI
From Thru PI	From Thru PI	From Thru PI
Onset > 4 mo: DOLBA: __	Onset > 4 mo: DOLBA: __	Onset > 4 mo: DOLBA: __

Prior Period 1:

MA: GI Bleed	MB: Pneumonia	MC: Pericarditis
Onset Date:	Onset Date:	Onset Date:
From Thru PI	From Thru PI	From Thru PI
From Thru PI	From Thru PI	From Thru PI
From Thru PI	From Thru PI	From Thru PI
From Thru PI	From Thru PI	From Thru PI
Onset > 4 mo: DOLBA: __	Onset > 4 mo: DOLBA: __	Onset > 4 mo: DOLBA: __

Retain 10 years of prior periods (this is what PRICERS have been made to do in order to rate adjustments back as far as 10 years)

Attachment 3: Outlier Services

Injectable Drugs		
Category	**HCPCS Code**	**Description**
Anemia management	J0882	DARBEPOETIN
Anemia management	J1756	IRON SUCROSE INJECTION
Anemia management	J2916	NA FERRIC GLUCONATE COMPLEX
Anemia management	J3420	VITAMIN B12 INJECTION
Anemia management	Q4081	EPO
Antiemetic	J0780	PROCHLORPERAZINE INJECTION
Antiemetic	J1260	DOLASETRON MESYLATE
Antiemetic	J1626	GRANISETRON HCL INJECTION
Antiemetic	J2405	ONDANSETRON HCL INJECTION
Antiemetic	J2550	PROMETHAZINE HCL INJECTION
Antiemetic	J2765	METOCLOPRAMIDE HCL INJECTION
Antiemetic	J2950	PROMAZINE HCL INJECTION
Antiemetic	J3230	CHLORPROMAZINE HCL INJECTION
Antiemetic	J3250	TRIMETHOBENZAMIDE HCL INJ
Antiemetic	J3310	PERPHENAZINE INJECTION
Anxiolytic	J2060	LORAZEPAM INJECTION
Anxiolytic	J2250	INJ MIDAZOLAM HYDROCHLORIDE
Anxiolytic	J3360	DIAZEPAM INJECTION
Bone and mineral metabolism	J0610	CALCIUM GLUCONATE INJECTION
Bone and mineral metabolism	J0630	CALCITONIN SALMON INJECTION
Bone and mineral metabolism	J0636	INJ CALCITRIOL PER 0.1 MCG
Bone and mineral metabolism	J0895	DEFEROXAMINE MESYLATE INJ
Bone and mineral metabolism	J1270	INJECTION, DOXERCALCIFEROL
Bone and mineral metabolism	J1740	IBANDRONATE SODIUM
Bone and mineral metabolism	J2430	PAMIDRONATE DISODIUM /30 MG
Bone and mineral metabolism	J2501	PARICALCITOL
Cellular management	J1955	INJ LEVOCARNITINE PER 1 GM
Pain management	J1170	HYDROMORPHONE INJECTION
Pain management	J1885	KETOROLAC TROMETHAMINE INJ
Pain management	J2175	MEPERIDINE HYDROCHL /100 MG
Pain management	J2270	MORPHINE SULFATE INJECTION
Pain management	J2271	MORPHINE SO4 INJECTION 100MG
Pain management	J2275	MORPHINE SULFATE INJECTION
Pain management	J2300	INJ NALBUPHINE HYDROCHLORIDE
Pain management	J2310	INJ NALOXONE HYDROCHLORIDE
Pain management	J3010	FENTANYL CITRATE INJECTION
Pain management	J3070	PENTAZOCINE INJECTION
Anti-infective *	J0278	AMIKACIN SULFATE
Anti-infective *	J0285	AMPHOTERICIN B
Anti-infective *	J0290	AMPICILLIN 500 MG INJ
Anti-infective *	J0295	AMPICILLIN SODIUM PER 1.5 GM
Anti-infective *	J0456	AZITHROMYCIN
Anti-infective *	J0530	PENICILLIN G BENZATHINE INJ
Anti-infective *	J0560	PENICILLIN G BENZATHINE INJ
Anti-infective *	J0580	PENICILLIN G BENZATHINE INJ
Anti-infective *	J0637	CASPOFUNGIN ACETATE
Anti-infective *	J0690	CEFAZOLIN SODIUM INJECTION
Anti-infective *	J0692	CEFEPIME HCL FOR INJECTION
Anti-infective *	J0694	CEFOXITIN SODIUM INJECTION
Anti-infective *	J0696	CEFTRIAXONE SODIUM INJECTION
Anti-infective *	J0697	STERILE CEFUROXIME INJECTION

Anti-infective *	J0698	CEFOTAXIME SODIUM INJECTION
Anti-infective *	J0713	INJ CEFTAZIDIME PER 500 MG
Anti-infective *	J0715	CEFTIZOXIME SODIUM / 500 MG
Anti-infective *	J0743	CILASTATIN SODIUM INJECTION
Anti-infective *	J0744	CIPROFLOXACIN IV
Anti-infective *	J0878	DAPTOMYCIN
Anti-infective *	J1335	ERTAPENEM SODICUM
Anti-infective *	J1364	ERYTHRO LACTOBIONATE /500 MG
Anti-infective *	J1450	FLUCONAZOLE
Anti-infective *	J1580	GARAMYCIN GENTAMICIN INJ
Anti-infective *	J1590	GATIFLOXACIN INJECTION
Anti-infective *	J1840	KANAMYCIN SULFATE 500 MG INJ
Anti-infective *	J1890	CEPHALOTHIN SODIUM INJECTION
Anti-infective *	J1956	LEVOFLOXACIN INJECTION
Anti-infective *	J2020	LINEZOLID INJECTION
Anti-infective *	J2185	MEROPENEM
Anti-infective *	J2280	MOXIFLOXACIN
Anti-infective *	J2510	PENICILLIN G PROCAINE INJ
Anti-infective *	J2540	PENICILLIN G POTASSIUM INJ
Anti-infective *	J2543	PIPERACILLIN/TAZOBACTAM
Anti-infective *	J2700	OXACILLIN SODIUM INJECTION
Anti-infective *	J3000	STREPTOMYCIN INJECTION
Anti-infective *	J3260	TOBRAMYCIN SULFATE INJECTION
Anti-infective *	J3370	VANCOMYCIN HCL INJECTION

Oral and Other Equivalent Forms of Injectable Drugs

Outlier Services Imputed Payment Amounts
Oral or Other Equivalent Forms of Part B Injectable Drugs Included in the ESRD PPS Bundle
(notwithstanding the delayed implementation of ESRD-related oral-only drugs effective 1/1/2014)

NDC	Drug Product	Mean Unit Cost
30698014301 30698014323 54868346100	Rocaltrol (calcitriol) 0.25 mcg capsules	$1.45
30698014401	Rocaltrol (calcitriol) 0.5 mcg capsules	$2.32
30698091115	Rocaltrol (calcitriol) 1 mcg/mL oral solution (15ml/bottle)	$12.30
00054000725 00054000713 00093065701 00440721599 54868458400 63304023901 63304023930 67544103581	Calcitriol 0.25 mcg capsules	$0.97
00093065801 54868458200 63304024001	Calcitriol 0.5 mcg capsules	$1.59
00054312041 63304024159	Calcitriol 1 mcg/mL oral solution (15ml/botle)	$9.94
00074431730	Zemplar (paricalcitol) 1 mcg capsule	$8.06
00074431430	Zemplar (paricalcitol) 2 mcg capsule	$16.10

00074431530	Zemplar (paricalcitol) 4 mcg capsule	$32.14
58468012101	Hectorol (doxercalciferol) 2.5 mcg capsule	$22.61
54482014407	Carnitor (levocarnitine) 330 mg tablet	$0.82
54482014508	Carnitor (levocarnitine) 1GM/10ML oral solution (118 mls)	$0.25
54482014801	Carnitor SF (levocarnitine) 1GM/10ML oral solution (118 mls)	$0.25
64980050312 50383017104	Levocarnitine 1GM/10ML oral solution (118 mls)	$0.20
64980013009 50383017290	Levocarnitine 330 mg tablet	$0.67

The mean dispensing fee of the NDCs listed above is $1.73. This amount will be applied to each NDC included on the monthly claim. We will limit 1 dispensing fee per NDC per month. Providers should report the quantity in the smallest available unit. This is necessary because Medicare is using the mean per unit cost in calculating the outlier. For example, if the provider reports NDC 00054312041 Calcitriol 1 mcg/ml oral solution (15/ml/bottle) and uses the full 15 ml bottle, the quantity is reported as 15, not 1. This allows for the most accurate calculation for the outlier.

Laboratory Tests

CPT/HCPCS	Short Description
82040 **	Assay of serum albumin
82108	Assay of aluminum
82247**	Bilirubin, total
82248**	Bilirubin, direct
82306	Vitamin d, 25 hydroxy
82310**	Assay of calcium
82330**	Assay of calcium, ionized
82374**	Assay, blood carbon dioxide
82379	Assay of carnitine
82435**	Assay of blood chloride
82465**	Assay, bld/serum cholesterol
82550**	Assay of ck (cpk)
82565**	Assay of creatinine
82570	Assay of urine creatinine

82575	Creatinine clearance test
82607	Vitamin B-12
82652	Vit d 1, 25-dihydroxy
82668	Assay of erythropoietin
82728	Assay of ferritin
82746	Blood folic acid serum
82947**	Assay, glucose, blood quant
82977**	Assay of GGT
83540	Assay of iron
83550	Iron binding test
83615**	Lactate (LD) (LDH) enzyme
83735	Assay of magnesium
83970	Assay of parathormone
84075**	Assay alkaline phosphatase
84100**	Assay of phosphorus
84132**	Assay of serum potassium
84134	Assay of prealbumin
84155**	Assay of protein, serum
84295**	Assay of serum sodium
84450**	Transferase (AST) (SGOT)
84460**	Alanine amino (ALT) (SGPT)
84466	Assay of transferrin
84478**	Assay of triglycerides
84520**	Assay of urea nitrogen
84540	Assay of urine/urea-n
84545	Urea-N clearance test
84550**	Assay blood/uric acid

85041	Automated rbc count
85044	Manual reticulocyte count
85045	Automated reticulocyte count
85046	Reticyte/hgb concentrate
85048	Automated leukocyte count
86704	Hep b core antibody, total
86705	Hep b core antibody, igm
86706	Hep b surface antibody
87040	Blood culture for bacteria
87070	Culture, bacteria, other
87071	Culture bacteri aerobic othr
87073	Culture bacteria anaerobic
87075	Cultr bacteria, except blood
87076	Culture anaerobe ident, each
87077	Culture aerobic identify
87081	Culture screen only
87340	Hepatitis b surface ag, eia
Syringes	
HCPCS Code	**Description**
A4657	Syringes with or with needle, each
A4913	Miscellaneous dialysis supplies, not otherwise specified

* Anti-infective drugs do not qualify as an outlier service when used at home by a patient to treat an infection of the catheter site or peritonitis associated with peritoneal dialysis.

** Automated Multi-Channel Chemistry tests only qualify as an outlier service when the 50/50 rule permits separate payment. More information regarding the 50/50 rule can be found in Pub. 100-02, Chapter 11, Section 30.2.2.

Attachment 4:

DME ESRD Supply HCPCS for ESRD PPS Consolidated Billing Edits

HCPC	Long Description
A4215	NEEDLE, STERILE, ANY SIZE, EACH
A4216	STERILE WATER, SALINE AND/OR DEXTROSE, DILUENT/FLUSH, 10 ML
A4217	STERILE WATER/SALINE, 500 ML
A4218	STERILE SALINE OR WATER, METERED DOSE DISPENSER, 10 ML
A4244	ALCOHOL OR PEROXIDE, PER PINT
A4245	ALCOHOL WIPES, PER BOX
A4246	BETADINE OR PHISOHEX SOLUTION, PER PINT
A4247	BETADINE OR IODINE SWABS/WIPES, PER BOX
A4248	CHLORHEXIDINE CONTAINING ANTISEPTIC, 1 ML
A4450	TAPE, NON-WATERPROOF, PER 18 SQUARE INCHES
A4452	TAPE, WATERPROOF, PER 18 SQUARE INCHES
A4657	SYRINGE, WITH OR WITHOUT NEEDLE, EACH
A4660	SPHYGMOMANOMETER/BLOOD PRESSURE APPARATUS WITH CUFF AND STETHOSCOPE
A4663	BLOOD PRESSURE CUFF ONLY
A4670	AUTOMATIC BLOOD PRESSURE MONITOR
A4927	GLOVES, NON-STERILE, PER 100
A4928	SURGICAL MASK, PER 20
A4930	GLOVES, STERILE, PER PAIR
A4931	ORAL THERMOMETER, REUSABLE, ANY TYPE, EACH
A6215	FOAM DRESSING, WOUND FILLER, STERILE, PER GRAM
A6250	SKIN SEALANTS, PROTECTANTS, MOISTURIZERS, OINTMENTS, ANY TYPE, ANY SIZE
A6260	WOUND CLEANSERS, STERILE, ANY TYPE, ANY SIZE
A6402	GAUZE, NON-IMPREGNATED, STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING
E0210	ELECTRIC HEAT PAD, STANDARD
E1639	SCALE, EACH

Attachment 5: DME ESRD Supply HCPCS Not Payable to DME Suppliers

HCPC	Long Description
A4651	CALIBRATED MICROCAPILLARY TUBE, EACH
A4652	MICROCAPILLARY TUBE SEALANT
A4653	PERITONEAL DIALYSIS CATHETER ANCHORING DEVICE, BELT, EACH
A4671	DISPOSABLE CYCLER SET USED WITH CYCLER DIALYSIS MACHINE, EACH
A4672	DRAINAGE EXTENSION LINE, STERILE, FOR DIALYSIS, EACH
A4673	EXTENSION LINE WITH EASY LOCK CONNECTORS, USED WITH DIALYSIS
A4674	CHEMICALS/ANTISEPTICS SOLUTION USED TO CLEAN/STERILIZE DIALYSIS EQUIPMENT, PER 8 OZ
A4680	ACTIVATED CARBON FILTER FOR HEMODIALYSIS, EACH
A4690	DIALYZER (ARTIFICIAL KIDNEYS), ALL TYPES, ALL SIZES, FOR HEMODIALYSIS, EACH
A4706	BICARBONATE CONCENTRATE, SOLUTION, FOR HEMODIALYSIS, PER GALLON
A4707	BICARBONATE CONCENTRATE, POWDER, FOR HEMODIALYSIS, PER PACKET
A4708	ACETATE CONCENTRATE SOLUTION, FOR HEMODIALYSIS, PER GALLON
A4709	ACID CONCENTRATE, SOLUTION, FOR HEMODIALYSIS, PER GALLON
A4714	TREATED WATER (DEIONIZED, DISTILLED, OR REVERSE OSMOSIS) FOR PERITONEAL DIALYSIS, PER GALLON
A4719	"Y SET" TUBING FOR PERITONEAL DIALYSIS
A4720	DIALYSATE SOLUTION, ANY CONCENTRATION OF DEXTROSE, FLUID VOLUME GREATER THAN 249CC, BUT LESS THAN OR EQUAL TO 999CC, FOR PERITONEAL DIALYSIS
A4721	DIALYSATE SOLUTION, ANY CONCENTRATION OF DEXTROSE, FLUID VOLUME GREATER THAN 999CC BUT LESS THAN OR EQUAL TO 1999CC, FOR PERITONEAL DIALYSIS
A4722	DIALYSATE SOLUTION, ANY CONCENTRATION OF DEXTROSE, FLUID VOLUME GREATER THAN 1999CC BUT LESS THAN OR EQUAL TO 2999CC, FOR PERITONEAL DIALYSIS

A4723	DIALYSATE SOLUTION, ANY CONCENTRATION OF DEXTROSE, FLUID VOLUME GREATER THAN 2999CC BUT LESS THAN OR EQUAL TO 3999CC, FOR PERITONEAL DIALYSIS
A4724	DIALYSATE SOLUTION, ANY CONCENTRATION OF DEXTROSE, FLUID VOLUME GREATER THAN 3999CC BUT LESS THAN OR EQUAL TO 4999CC, FOR PERITONEAL DIALYSIS
A4725	DIALYSATE SOLUTION, ANY CONCENTRATION OF DEXTROSE, FLUID VOLUME GREATER THAN 4999CC BUT LESS THAN OR EQUAL TO 5999CC, FOR PERITONEAL DIALYSIS
A4726	DIALYSATE SOLUTION, ANY CONCENTRATION OF DEXTROSE, FLUID VOLUME GREATER THAN 5999CC, FOR PERITONEAL DIALYSIS
A4728	DIALYSATE SOLUTION, NON-DEXTROSE CONTAINING, 500 ML
A4730	FISTULA CANNULATION SET FOR HEMODIALYSIS, EACH
A4736	TOPICAL ANESTHETIC, FOR DIALYSIS, PER GRAM
A4737	INJECTABLE ANESTHETIC, FOR DIALYSIS, PER 10 ML
A4740	SHUNT ACCESSORY, FOR HEMODIALYSIS, ANY TYPE, EACH
A4750	BLOOD TUBING, ARTERIAL OR VENOUS, FOR HEMODIALYSIS, EACH
A4755	BLOOD TUBING, ARTERIAL AND VENOUS COMBINED, FOR HEMODIALYSIS, EACH
A4760	DIALYSATE SOLUTION TEST KIT, FOR PERITONEAL DIALYSIS, ANY TYPE, EACH
A4765	DIALYSATE CONCENTRATE, POWDER, ADDITIVE FOR PERITONEAL DIALYSIS, PER PACKET
A4766	DIALYSATE CONCENTRATE, SOLUTION, ADDITIVE FOR PERITONEAL DIALYSIS, PER 10 ML
A4770	BLOOD COLLECTION TUBE, VACUUM, FOR DIALYSIS, PER 50
A4771	SERUM CLOTTING TIME TUBE, FOR DIALYSIS, PER 50
A4772	BLOOD GLUCOSE TEST STRIPS, FOR DIALYSIS, PER 50
A4773	OCCULT BLOOD TEST STRIPS, FOR DIALYSIS, PER 50
A4774	AMMONIA TEST STRIPS, FOR DIALYSIS, PER 50
A4802	PROTAMINE SULFATE, FOR HEMODIALYSIS, PER 50 MG
A4860	DISPOSABLE CATHETER TIPS FOR PERITONEAL DIALYSIS, PER 10
A4870	PLUMBING AND/OR ELECTRICAL WORK FOR HOME HEMODIALYSIS EQUIPMENT
A4890	CONTRACTS, REPAIR AND MAINTENANCE, FOR HEMODIALYSIS EQUIPMENT
A4911	DRAIN BAG/BOTTLE, FOR DIALYSIS, EACH
A4913	MISCELLANEOUS DIALYSIS SUPPLIES, NOT OTHERWISE SPECIFIED
A4918	VENOUS PRESSURE CLAMP, FOR HEMODIALYSIS, EACH

A4929	TOURNIQUET FOR DIALYSIS, EACH
E1500	CENTRIFUGE, FOR DIALYSIS
E1510	KIDNEY, DIALYSATE DELIVERY SYST. KIDNEY MACHINE, PUMP RECIRCULAT- ING, AIR REMOVAL SYST, FLOWRATE METER, POWER OFF, HEATER AND TEMPERATURE CONTROL WITH ALARM, I.V.POLES, PRESSURE GAUGE, CONCENTRATE CONTAINER
E1520	HEPARIN INFUSION PUMP FOR HEMODIALYSIS
E1530	AIR BUBBLE DETECTOR FOR HEMODIALYSIS, EACH, REPLACEMENT
E1540	PRESSURE ALARM FOR HEMODIALYSIS, EACH, REPLACEMENT
E1550	BATH CONDUCTIVITY METER FOR HEMODIALYSIS, EACH
E1560	BLOOD LEAK DETECTOR FOR HEMODIALYSIS, EACH, REPLACEMENT
E1570	ADJUSTABLE CHAIR, FOR ESRD PATIENTS
E1575	TRANSDUCER PROTECTORS/FLUID BARRIERS, FOR HEMODIALYSIS, ANY SIZE, PER 10
E1580	UNIPUNCTURE CONTROL SYSTEM FOR HEMODIALYSIS
E1590	HEMODIALYSIS MACHINE
E1592	AUTOMATIC INTERMITTENT PERITIONEAL DIALYSIS SYSTEM
E1594	CYCLER DIALYSIS MACHINE FOR PERITONEAL DIALYSIS
E1600	DELIVERY AND/OR INSTALLATION CHARGES FOR HEMODIALYSIS EQUIPMENT
E1610	REVERSE OSMOSIS WATER PURIFICATION SYSTEM, FOR HEMODIALYSIS
E1615	DEIONIZER WATER PURIFICATION SYSTEM, FOR HEMODIALYSIS
E1620	BLOOD PUMP FOR HEMODIALYSIS, REPLACEMENT
E1625	WATER SOFTENING SYSTEM, FOR HEMODIALYSIS
E1630	RECIPROCATING PERITONEAL DIALYSIS SYSTEM
E1632	WEARABLE ARTIFICIAL KIDNEY, EACH
E1634	PERITONEAL DIALYSIS CLAMPS, EACH
E1635	COMPACT (PORTABLE) TRAVEL HEMODIALYZER SYSTEM
E1636	SORBENT CARTRIDGES, FOR HEMODIALYSIS, PER 10
E1637	HEMOSTATS, EACH
E1699	DIALYSIS EQUIPMENT, NOT OTHERWISE SPECIFIED

Attachment: 6: LABS SUBJECT TO ESRD CONSOLIDATED BILLING

CPT/ HCPCS	Short Description
82040	**Assay of serum albumin**
82108	Assay of aluminum
82306	Vitamin d, 25 hydroxy
82310	Assay of calcium
82330	Assay of calcium, Ionized
82374	Assay, blood carbon dioxide
82379	Assay of carnitine
82435	Assay of blood chloride
82565	Assay of creatinine
82570	Assay of urine creatinine
82575	Creatinine clearance test
82607	Vitamin B-12
82652	Vit d 1, 25-dihydroxy
82668	Assay of erythropoietin
82728	Assay of ferritin
82746	Blood folic acid serum
83540	Assay of iron
83550	Iron binding test
83735	Assay of magnesium
83970	Assay of parathormone
84075	Assay alkaline phosphatase
84100	Assay of phosphorus
84132	Assay of serum potassium
84134	Assay of prealbumin
84155	Assay of protein, serum
84295	Assay of serum sodium
84466	Assay of transferrin
84520	Assay of urea nitrogen
84540	Assay of urine/urea-n
84545	Urea-N clearance test
85014	Hematocrit
85018	Hemoglobin
85025	Complete (cbc), automated (HgB, Hct, RBC, WBC, and Platelet count) and automated differential WBC count.
85027	Complete (cbc), automated (HgB, Hct, RBC, WBC, and Platelet count)

85041	Automated rbc count
85044	Manual reticulocyte count
85045	Automated reticulocyte count
85046	Reticyte/hgb concentrate
85048	Automated leukocyte count
86704	Hep b core antibody, total
86705	Hep b core antibody, igm
86706	Hep b surface antibody
87040	Blood culture for bacteria
87070	Culture, bacteria, other
87071	Culture bacteri aerobic othr
87073	Culture bacteria anaerobic
87075	Cultr bacteria, except blood
87076	Culture anaerobe ident, each
87077	Culture aerobic identify
87081	Culture screen only
87340	Hepatitis b surface ag, eia
G0306	CBC/diff wbc w/o platelet
G0307	CBC without platelet

Attachment 7: Drugs Subject to ESRD Consolidated Billing

Category	HCPCS	Title
Access management	J1642	INJ HEPARIN SODIUM PER 10 U
	J1644	INJ HEPARIN SODIUM PER 1000U
	J1945	LEPIRIDUN
	J2993	RETEPLASE INJECTION
	J2997	ALTEPLASE RECOMBINANT
	J3364	UROKINASE 5000 IU INJECTION
	J3365	UROKINASE 250,000 IU INJ
Anemia management	J0882	DARBEPOETIN
	J1756	IRON SUCROSE INJECTION
	J2916	NA FERRIC GLUCONATE COMPLEX
	J3420	VITAMIN B12 INJECTION
	Q4081	EPO
	J2250	INJ MIDAZOLAM HYDROCHLORIDE
	J3360	DIAZEPAM INJECTION
	J0610	CALCIUM GLUCONATE INJECTION
	J0630	CALCITONIN SALMON INJECTION
	J0635	CALCITRIOL
	J0636	INJ CALCITRIOL PER 0.1 MCG
	J0895	DEFEROXAMINE MESYLATE INJ
	J1270	INJECTION, DOXERCALCIFEROL
	J1740	IBANDRONATE SODIUM
	J2430	PAMIDRONATE DISODIUM /30 MG
	J2501	PARICALCITOL
Cellular management	J1955	INJ LEVOCARNITINE PER 1 GM
Anti-infectives	J0878	DAPTOMYCIN
	J3370	VANCOMYCIN HCL INJECTION

Attachment 8: Comorbid Categories and Diagnosis Codes

Acute Comorbid Conditions

Gastrointestinal Bleeding

ICD-9-CM	Descriptor
53021	Ulcer of esophagus with bleeding
53100	Acute gastric ulcer with hemorrhage without mention of obstruction
53101	Acute gastric ulcer with hemorrhage with obstruction
53120	Acute gastric ulcer with hemorrhage and perforation without mention of obstruction
53121	Acute gastric ulcer with hemorrhage and perforation with obstruction
53140	Chronic or unspecified gastric ulcer with hemorrhage without mention of obstruction
53141	Chronic or unspecified gastric ulcer with hemorrhage with obstruction
53160	Chronic or unspecified gastric ulcer with hemorrhage and perforation without mention of obstruction
53161	Chronic or unspecified gastric ulcer with hemorrhage and perforation with obstruction
53200	Acute duodenal ulcer with hemorrhage without mention of obstruction
53201	Acute duodenal ulcer with hemorrhage with obstruction
53220	Acute duodenal ulcer with hemorrhage and perforation without mention of obstruction
53221	Acute duodenal ulcer with hemorrhage and perforation with obstruction
53240	Chronic or unspecified duodenal ulcer with hemorrhage without mention of obstruction
53241	Chronic or unspecified duodenal ulcer with hemorrhage with obstruction
53260	Chronic or unspecified duodenal ulcer with hemorrhage and perforation without mention of obstruction
53261	Chronic or unspecified duodenal ulcer with hemorrhage and perforation with obstruction
53300	Acute peptic ulcer with hemorrhage without mention of obstruction
53301	Acute peptic ulcer with hemorrhage with obstruction
53320	Acute peptic ulcer with hemorrhage and perforation without mention of obstruction
53321	Acute peptic ulcer with hemorrhage and perforation with obstruction
53340	Chronic or unspecified peptic ulcer with hemorrhage without mention of obstruction
53341	Chronic or unspecified peptic ulcer with hemorrhage with obstruction

53360	Chronic or unspecified peptic ulcer with hemorrhage and perforation without mention of obstruction
53361	Chronic or unspecified peptic ulcer with hemorrhage and perforation with obstruction
53400	Acute gastrojejunal ulcer with hemorrhage without mention of obstruction
53401	Acute gastrojejunal ulcer with hemorrhage with obstruction
53420	Acute gastrojejunal ulcer with hemorrhage and perforation without mention of obstruction
53421	Acute gastrojejunal ulcer with hemorrhage and perforation with obstruction
53440	Chronic or unspecified gastrojejunal ulcer with hemorrhage without mention of obstruction
53441	Chronic or unspecified gastrojejunal ulcer with hemorrhage with obstruction
53460	Chronic or unspecified gastrojejunal ulcer with hemorrhage and perforation without mention of obstruction
53461	Chronic or unspecified gastrojejunal ulcer with hemorrhage and perforation with obstruction
53571	Eosinophilic gastritis, with hemorrhage
53783	Angiodysplasia of stomach and duodenum with hemorrhage
56202	Diverticulosis of small intestine with hemorrhage
56203	Diverticulitis if small intestine with hemorrhage
56212	Diverticulosis of colon with hemorrhage
56213	Diverticulitis if colon with hemorrhage
56985	Angiodysplasia of intestine with hemorrhage

Bacterial Pneumonia

ICD-9-CM	Descriptor
00322	Salmonella pneumonia
4820	Pneumonia due to Klebsiella pneumnoniae
4821	Pneumonia due to Pseudomonas
4822	Pneumonia due to Hemophilus influenza (H. influenza)
48230	Pneumonia due to Streptococcus, unspecified
48231	Pneumonia due to Streptococcus, Group A
48232	Pneumonia due to Streptococcus, Group B

48239	Pneumonia due to other Streptococcus
48240	Pneumonia due to Staphylococcus, unspecified
48241	Methicillin susceptible pneumonia due to Staphylococcus aureus
48242	Methicillin resistant pneumonia due to Staphylococcus aureus
48249	Other Staphylococcus pneumonia
48281	Pneumonia due to Anaerobes
48282	Pneumonia due to Escherichia coli (E. coli)
48283	Pneumonia due to other gram-negative bacteria
48284	Pneumonia due to Legionnaires' disease
48289	Pneumonia due to other specified bacteria
4846	Pneumonia in aspergillosis
4847	Pneumonia in other systemic mycoses
5070	Pneumonitis due to inhalation of food or vomitus
5078	Pneumonitis due to other solids and liquids
5100	Empyema, with fistula
5109	Empyema. without mention of fistula
5130	Abscess of lung

Pericarditis

ICD-9-CM	Descriptor
4200	Acute pericarditis in diseases classified elsewhere
42090	Other and unspecified pericarditis, acute pericarditis, unspecified
42091	Other and unspecified pericarditis, acute idiopathic paricarditis
42099	Other acute pericarditis

Chronic Comorbid Conditions

Hereditary hemolytic and sickle cell anemia

ICD-9-CM	Descriptor

2820	Hereditary spherocytosis
2821	Hereditary elliptocytosis
2822	Anemias due to disorders of glutathione metabolism
2823	Other hemolytic anemias due to enzyme deficiency
28241	Sickle-cell thalassemia without crisis
28242	Sickle-cell thalassemia with crisis
28249	Other thalassemias
28261	Sickle-cell disease, Hb-SS disease without crisis
28262	Sickle-cell disease, Hb-SS disease with crisis
28263	Sickle-cell disease, Sickle-cell/Hb-C disease without crisis
28264	Sickle-cell disease, Sickle-cell/Hb-C disease with crisis
28268	Sickle-cell disease, Other sickle-cell disease without crisis
28269	Sickle-cell disease, Other sickle-cell disease with crisis

Monoclonal gammopathy (in the absence of multiple myeloma)

ICD-9-CM	Descriptor
2731	Monoclonal paraproteinemia [includes monoclonal gammopathy]

Myelodysplastic syndrome

ICD-9-CM	Descriptor
23871	Essential thrombocythemia
23872	Low grade myelodysplastic syndrome lesions
23873	High grade myelodysplastic syndrome lesions
23874	Myelodysplastic syndrome with 5q deletion
23875	Myelodysplastic syndrome, unspecified
23876	Myelofibrosis with myeloid metaplasia