

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2269	Date: August 5, 2011
	Change Request 7520

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

I. SUMMARY OF CHANGES: In CY 2011 Physician Fee Schedule (PFS) final rule with comment period (75 FR 73295-73296), CMS required monthly capitation payment (MCP) physicians or practitioners furnish at least one face-to-face patient visit per month for the home dialysis MCP service as described by CPT codes 90963, 90964, 90965, and 90966. Documentation by the MCP physician or practitioner should support at least one face-to-face encounter per month with the home dialysis patient. For required MCP visits for center based patients and home dialysis patients, the MCP physician or practitioner may use other Medicare certified physicians or practitioners to provide some of the visits during the month. Visits must be furnished face-to-face by a physician, clinical nurse specialist, nurse practitioner, or physician's assistant. The MCP physician or practitioner does not have to be present when these other physicians or practitioners provide visits. The non-MCP physician or practitioner must be a partner, an employee of the same group practice, or an employee of the MCP physician or practitioner. For example, the physician or practitioner furnishing visits under the MCP may be either a W-2 employee or 1099 independent contractor.

EFFECTIVE DATE: January 1, 2011

IMPLEMENTATION DATE: November 7, 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/revise 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	8/140.1/Payment for ESRD-Related Services Under the Monthly Capitation Payment (Center Based Patients)
R	8/140.1.1/Payment for Managing Patients on Home Dialysis

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: 2269	Date: August 5, 2011	Change Request: 7520
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SUBJECT: Clarification of Payment for ESRD-Related Services Under the Monthly Capitation Payment

Effective Date: January 1, 2011

Implementation Date: November 7, 2011

I. GENERAL INFORMATION

A. Background: In the CY 2004 physician fee schedule (PFS) final rule with comment period (68 FR 63216), CMS established new G codes for the end stage renal disease (ESRD) monthly capitation payment (MCP). For center-based patients, payment for the G codes varied based on the age of the beneficiary and the number of face to face visits furnished each month (e.g. 1 visit, 2-3 visits and 4 or more visits). Under this methodology, the lowest payment amount applies when a physician provides one visit per month; a higher payment is provided for two to three visits per month. To receive the highest payment amount, a physician would have to provide at least four ESRD related visits per month. However, payment for the home dialysis MCP only varied by the age of beneficiary. CMS stated that “we will not specify the frequency of required visits at this time but expect physicians to provide clinically appropriate care to manage the home dialysis patient.”

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

In CY 2011 Physician Fee Schedule (PFS) final rule with comment period (75 FR 73295-73296), CMS required MCP physicians or practitioners furnish at least one face-to-face patient visit per month for the home dialysis MCP service as described by CPT codes 90963, 90964, 90965, and 90966. Documentation by the MCP physician or practitioner should support at least one face-to-face encounter per month with the home dialysis patient. However, Medicare contractors may waive the requirement for a monthly face-to-face visit for the home dialysis MCP service on a case by case basis; for example, when the nephrologist’s notes indicate that the physician actively and adequately managed the care of the home dialysis patient throughout the month.

B. Policy: Visits furnished by another physician or practitioner (who is not the MCP physician or practitioner).

For required MCP visits for center based patients and home dialysis patients, the MCP physician or practitioner may use other Medicare certified physicians or practitioners to provide some of the visits during the month. Visits must be furnished face-to-face by a physician, clinical nurse specialist, nurse practitioner, or physician’s assistant. The MCP physician or practitioner does not have to be present when these other physicians or practitioners provide visits. The non-MCP physician or practitioner must be a partner, an employee of the same group practice, or an employee of the MCP physician or practitioner. For example, the physician or practitioner furnishing visits under the MCP may be either a W-2 employee or 1099 independent contractor.

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

and establishes the plan of care, then the MCP service should be billed under the PIN of the clinical nurse specialist, nurse practitioner, or physician assistant.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)								
		A / B M A C	D M E M A C	F I I E R	C A R R I E R	R H H I	Shared-System Maintainers			
						F I S S	M C S	V M S	C W F	
7520.1	Medicare contractors shall make payment for the home dialysis MCP service (codes 90951 – 90966), even when a physician or qualified nonphysician practitioner, other than the MCP physician/practitioner, furnishes the required face-to-face visit(s), as described by the Medicare Claims Processing Manual, Pub. 100-04, chapter 8, section 140.	X			X					
7520.2	Contractors shall not search their files to adjust claims already processed, but shall adjust claims brought to their attention within a timely filing period.	X			X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)								
		A / B M A C	D M E M A C	F I I E R	C A R R I E R	R H H I	Shared-System Maintainers			
						F I S S	M C S	V M S	C W F	
7520.3	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					

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

“Should” denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Erin Smith, (410) 786-0763, erin.smith@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)*, *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.

Section B: For *Medicare Administrative Contractors (MACs)*, include 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.

Medicare Claims Processing Manual

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

140.1 - Payment for ESRD-Related Services Under the Monthly Capitation Payment (Center Based Patients)

(Rev.2269, Issued: 08-05-11, Effective: 01-01-11, Implementation: 11-07-11)

Physicians and practitioners managing center based patients on dialysis are paid a monthly rate for most outpatient dialysis-related physician services furnished to a Medicare ESRD beneficiary. The payment amount varies based on the number of visits provided within each month and the age of the ESRD beneficiary. Under this methodology, separate codes are billed for providing one visit per month, two to three visits per month and four or more visits per month. The lowest payment amount applies when a physician provides one visit per month; a higher payment is provided for two to three visits per month. To receive the highest payment amount, a physician or practitioner would have to provide at least four ESRD-related visits per month. The MCP is reported once per month for services performed in an outpatient setting that are related to the patients' ESRD.

The physician or practitioner who provides the complete assessment, establishes the patient's plan of care, and provides the ongoing management is the physician or practitioner who submits the bill for the monthly service.

a. Month defined.

For purposes of billing for physician and practitioner ESRD related services, the term 'month' means a calendar month. The first month the beneficiary begins dialysis treatments is the date the dialysis treatments begin through the end of the calendar month. Thereafter, the term 'month' refers to a calendar month.

b. Determination of the age of beneficiary.

The beneficiary's age at the end of the month is the age of the patient for determining the appropriate age related ESRD-related services code.

c. Qualifying Visits Under the MCP

- General policy.

Visits must be furnished face-to-face by a physician, clinical nurse specialist, nurse practitioner, or physician's assistant.

- Visits furnished by another physician or practitioner (who is not the MCP physician or practitioner).

The MCP physician or practitioner may use other physicians or *qualified nonphysician* practitioners to provide some of the visits during the month. The MCP physician or practitioner does not have to be present when these other physicians or practitioners provide visits. In this instance, the rules are consistent with the requirements for *hospital* split/shared evaluation and management visits. The non-MCP physician or practitioner must be a partner, an employee of the same group practice, or an employee of the MCP physician or practitioner. For example, the physician or practitioner furnishing visits under the MCP may be either a W-2 employee or 1099 independent contractor.

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

If the nonphysician practitioner is the practitioner who performs the complete assessment and establishes the plan of care, then the MCP service should be billed under the PIN of the clinical nurse specialist, nurse practitioner, or physician assistant.

- Residents, interns and fellows.

Patient visits by residents, interns and fellows enrolled in an approved Medicare graduate medical education (GME) program may be counted towards the MCP visits if the teaching MCP physician is present during the visit.

- Patients designated/admitted as hospital observation status.

ESRD-related visits furnished to patients in hospital observation status that occur on or after January 1, 2005, should be counted for purposes of billing the MCP codes. Visits furnished to patients in hospital observation status are included when submitting MCP claims for ESRD-related services.

- ESRD-related visits furnished to beneficiaries residing in a SNF.

ESRD-related visits furnished to beneficiaries residing in a SNF should be counted for purposes of billing the MCP codes.

- SNF residents admitted as an inpatient.

Inpatient visits are not counted for purposes of the MCP service. If the beneficiary residing in a SNF is admitted to the hospital as an inpatient, the appropriate inpatient visit code should be billed.

- ESRD Related Visits as a Telehealth Service

ESRD-related services with 2 or 3 visits per month and ESRD-related services with 4 or more visits per month may be furnished as a telehealth service. However, at least one visit per month is required in person to examine the vascular access site. A clinical examination of the vascular access site must be furnished face-to-face (not as a telehealth service) by a physician, nurse practitioner or physician's assistant. For more information on how ESRD-related visits may be furnished as a Medicare telehealth service and for general Medicare telehealth policy see Pub. 100-02, Medicare Benefit Policy manual, chapter 15, section 270. For claims processing instructions see Pub. 100-04, Medicare Claims Processing manual chapter 12, section 190.

140.1.1 - Payment for Managing Patients on Home Dialysis

(Rev. 2269, Issued: 08-05-11, Effective: 01-01-11, Implementation: 11-07-11)

Physicians and practitioners managing ESRD patients who dialyze at home are paid a single monthly rate based on the age of the beneficiary. The MCP physician (or practitioner) must furnish at least one face-to-face patient visit per month for the home dialysis MCP service. Documentation by the MCP physician (or practitioner) should support at least one face-to-face encounter per month with the home dialysis patient. Medicare contractors may waive the requirement for a monthly face-to-face visit for the home dialysis MCP service on a case by case basis, for example, when the nephrologist's notes indicate that the physician actively and adequately managed the care of the home dialysis patient throughout the month. The management of home dialysis patients who remain a home dialysis patient the entire month should be coded using the ESRD-related services for home dialysis patients HCPCS codes.

a. Month defined.

For purposes of billing for physician and practitioner ESRD related services, the term 'month' means a calendar month. The first month the beneficiary begins dialysis treatments is the date the dialysis treatments begin through the end of the calendar month. Thereafter, the term 'month' refers to a calendar month.

b. Qualifying Visits under the MCP

- *General policy.*

Visits must be furnished face-to-face by a physician, clinical nurse specialist, nurse practitioner, or physician's assistant.

- *Visits furnished by another physician or practitioner (who is not the MCP physician or practitioner).*

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

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

If the nonphysician practitioner is the practitioner who performs the complete assessment and establishes the plan of care, then the MCP service should be billed under the PIN of the clinical nurse specialist, nurse practitioner, or physician assistant.

- *Residents, interns and fellows.*

Patient visits by residents, interns and fellows enrolled in an approved Medicare graduate medical education (GME) program may be counted towards the MCP visits if the teaching MCP physician is present during the visit.