

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1084	Date: OCTOBER 27, 2006
	Change Request 5039

Subject: Line Item Billing Requirement for End Stage Renal Disease (ESRD) Claims

I. SUMMARY OF CHANGES: This instruction includes manual revisions for ESRD claims required to be billed with line item date of service detail for claims with dates of service on or after April 1, 2007. Other revisions are included to update or remove outdated material and do not reflect new or changing policy.

New / Revised Material

Effective Date: April 1, 2007

Implementation Date: April 2, 2007

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/ Table of Contents
R	8/10.6/ Amount of Payment
R	8/20.1/ Calculation of Case Mix Adjusted Composite Rate
R	8/50.1/ Laboratory Services Included in the Composite Rate
R	8/50.2/ Drugs and Biologicals Included in the Composite Rate
R	8/50.3/ Required Information for In-Facility Claims Paid Under the Composite Rate
R	8/50.4/Reserve for Future Use
R	8/50.5/ IPD in the Facility
R	8/50.8/ Training and Retraining
R	8/50.9/ Coding Adequacy of Hemodialysis
R	8/60.1/Lab Services
R	8/60.2/Drugs Furnished in Dialysis Facilities

R	8/60.2.1/Billing Procedures for Drugs for Facilities
R	8/60.4.3/ Payment Amount for Epoetin Alfa (EPO)
R	8/60.6/ Vaccines Furnished to ESRD Patients
R	8/70.1/ Method Selection for Home Dialysis Payment
R	8/80.2.1/ Required Billing Information for Method I Claims
R	8/80.3.1/IPD at Home for Method I Claims Submitted to the Intermediary
R	8/80.3/ Calculating Payment for Intermittent Peritoneal Dialysis (IPD) for Method 1 Claims Submitted to the Intermediary
R	8/80.4/ Calculating Payment for for Continuous Ambulatory Peritoneal Dialysis (CAPD) and Continuous Cycling Peritoneal Dialysis (CCPD) Under the Composite Rate

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1084	Date: October 27, 2006	Change Request: 5039
-------------	-------------------	------------------------	----------------------

SUBJECT: Line Item Billing Requirement for End Stage Renal Disease (ESRD) Claims

I. GENERAL INFORMATION

A. Background: The Centers for Medicare and Medicaid Services (CMS) in compliance with the Health Insurance Portability and Accountability Act (HIPAA) Implementation Guide, requires that all outpatient claims contain a line item date of service for each revenue code billed on the claim. The CMS has completed implementation of line item billing for most institutional Part B claims and has encouraged the renal dialysis facilities (RDFs) to begin line item billing. CMS has permitted the RDFs to continue to roll-up the services provided through-out the month and choose one date of service within the billing period on the claim to report all instances of each revenue code on a single line. As a result, ESRD claims are currently being received and processed using both methods; line item billing and services rolled-up for all instances of each revenue code.

The CMS does not believe the method of rolling up all instances of each revenue code on a single line provides the most accurate claims data since the claim is reporting that all of a given service is provided on the same date. Inherent with this method of billing is an increase in the number of claims that cannot be processed to payment due to claims with overlapping dates of service. In these overlapping claim cases, the RDFs must report service dates of other providers within the month they are billing using an occurrence span code 74 on the claim in order to prevent the overlap of the claims and allow both claims to be paid. The CMS has continually been told by RDFs that this is a difficult task as they are not always informed of the beneficiary receiving services performed by other providers.

The Medicare claims processing system has the capability to compare services on multiple claims to the line date that could prevent both the unnecessary suspension of claims for overlapping billing periods and the reporting of the occurrence span code 74 for the RDFs. In order to apply this system functionality to the ESRD claims, the claim must provide the line item date of service detail for each service being billed on the claim. This is a substantial benefit that line item billing can provide for ESRD claims.

Benefits of line item billing include:

- More accurate and timely claim payments to providers.
- Less staff time needed to research dates of services performed by other providers.
- Clinical data will no longer need to be rolled up to accommodate the claims processing systems and therefore, will more closely match the claim record.
- More detailed claim data could be used to assist the CMS in future refinements to improve the accuracy and equity of ESRD payments.
- Ensures that both the CMS and its providers are HIPAA compliant for submitting the appropriate line item date of service.

B. Policy: Line item billing is required for all ESRD claims with dates of service on or after April 1, 2007. The RDFs shall report the appropriate line item date of service to conform with the date the service was provided to the beneficiary. RDFs are required to bill all services with line item date of service detail except supplies and epoetin alfa (EPO). Any changes in the billing for EPO will be issued under a separate instruction. Each dialysis session performed should be reported on a separate line. The units reported on the line for each date dialysis was performed should not exceed one.

Coding Adequacy for Hemodialysis:

The HCPCS code 90999 (unlisted dialysis procedure, inpatient or outpatient) and modifiers G1 through G6 used for reporting the urea reduction ratio (URR) for determining the adequacy of hemodialysis must be reported on all claims billing for hemodialysis sessions, however it is not required that it be reported on every line item that contains a hemodialysis session.

Home Dialysis Under Method One:

For intermittent home dialysis under method one, the provider would submit a separate line item for each dialysis session using the dates in the pre-determined plan of care schedule provided to the beneficiary unless informed by the beneficiary that the schedule was changed. In the event that the schedule was changed, the provider should note the changes in the medical record and bill according to the revised schedule.

For Continuous Ambulatory Peritoneal Dialysis (CAPD) and Continuous Cycling Peritoneal Dialysis (CCPD) under method one, the provider would submit a separate line item for the dialysis for each day of the month. If the provider is aware of an inpatient stay for the beneficiary within the month, the RDF may include the date of admission and date of discharge as a billable day for the dialysis but should omit the dates within the inpatient stay. In the event that the RDF is unaware of an inpatient stay during the month, the Medicare system shall detect the overlapping dates and reject only the line item dates within the inpatient stay but pay the remainder of the claim for any dates that are not within the inpatient stay.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement

"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		F	R	C	D	Shared System Maintainers				Other
		I	H	a	M	F	M	V	C	
			I	r	E	I	C	S	W	
				r	R	S	S	S	F	
				e	C					
				r						

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
5039.1	Medicare systems shall apply the ESRD pricer daily rate to each line item dialysis session billed.					X				
5039.2	Medicare contractors shall require line item billing on bill type 72x as described in the Policy Section 1. B. above.	X				X				
5039.2.1	Medicare systems shall return the claim to the provider when the units reported on lines containing revenue codes 821, 831, 841 and 851 exceed 1.					X				
5039.2.2	Medicare systems shall discontinue the requirement of value code 67 (total monthly IPD hours).					X				
5039.2.3	Medicare systems shall require the HCPCS 90999 with modifiers G1 through G6 be present on one revenue code 0821 line per claim. Note: CMS does not require the URR for adequacy of hemodialysis to be reported on every line containing revenue code 0821.					X				
5039.2.4	Medicare systems shall ensure that the total reimbursement for EPO remains the same when apportioned to each line when claims contain multiple lines of revenue codes 0634 and/or 0635.					X				
5039.3	Medicare systems shall discontinue the requirement for the occurrence span code 74 on bill type 72x by comparing overlapping claims to the line item dates billed on the claim(s).					X			X	
5039.3.1	For 72x claims overlapping another 72x claim, Medicare systems shall compare the claims line item date of service and revenue code and HCPCS when applicable for duplicate services.					X			X	

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)							
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers			
F I S S	M C S					V M S	C W F		
	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 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. 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.								

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

<p>Effective Date*: April 1, 2007</p> <p>Implementation Date: April 2, 2007</p> <p>Pre-Implementation Contact(s): Wendy.Tucker@cms.hhs.gov, 410-786-3004</p> <p>Jason.Kerr@cms.hhs.gov, 410-786-2123</p> <p>Post-Implementation Contact(s): Appropriate RO.</p>	<p>No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.</p>
---	--

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

Medicare Claims Processing Manual

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

Table of Contents *(Rev. 1084, 10-27-06)*

50.4 – Reserved for future use

10.6 - Amount of Payment

(Rev. 1084, Issued: 10-27-06; Effective: 04-01-07; Implementation: 04-02-07)

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.

20.1 – Calculation of Case Mix Adjusted Composite Rate

(Rev. 1084, Issued: 10-27-06; Effective: 04-01-07; Implementation: 04-02-07)

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:

Claim Items	UB-92	ASC X12N 837i
Through Date	FL 6	2300 DTP <i>segment</i> / 434 <i>qualifier</i>
Date of Birth	FL 14	2010BA DMG02
Condition Code (73 or 74)	FL 24-30	2300 HI <i>segment</i> BG <i>qualifier</i>
Value Codes (A8 and A9) / Amounts	FL 39-41	2300 HI <i>segment</i> BE <i>qualifier</i>
Revenue Code (0821, 0831, 0841, 0851, 0880, or 0881)	FL 42	2400 SV201

The following provider data must also be passed to the ESRD PRICER to make provider-specific calculations that determine the final ESRD composite 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)
ESRD Rate from FISS Map 1105 or 105A or B	9(7)V9(2)

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)

50.1 - Laboratory Services Included in the Composite Rate

(Rev. 1084, Issued: 10-27-06; Effective: 04-01-07; Implementation: 04-02-07)

The costs of certain ESRD laboratory services performed by either the ESRD facility or an independent laboratory are included in the composite rate calculations. Therefore, payment for all of these tests is included in the composite rate and may NOT be billed separately to the Medicare program. For an exception, see the discussion of ESRD related laboratory tests in Chapter 16 of this manual.

These tests are either performed by the facility, in which case payment is included in the composite rate, or by an outside laboratory for the facility, in which case the laboratory bills the facility, which is paid only under the composite rate.

For the laboratory tests and the frequency of coverage included in the composite rate for hemodialysis, intermittent peritoneal dialysis and continuous cycling peritoneal dialysis see the Medicare Benefit Policy Manual (100-2, Chapter 11, Section 30.2).

For the laboratory tests and the frequency of coverage included in the composite rate for continuous ambulatory peritoneal see the Medicare Benefit Policy Manual (100-2, Chapter 11, Section 70.2).

50.2 - Drugs and Biologicals Included in the Composite Rate

(Rev. 1084, Issued: 10-27-06; Effective: 04-01-07; Implementation: 04-02-07)

Certain drugs used in the dialysis procedure are covered under the facility's composite rate and may not be billed separately. Drugs that are used as a substitute for any of these items or are used to accomplish the same effect are also included in the composite rate. The administration of these items (both staff time and supplies) is covered under the composite rate and may not be billed separately. Self-administered items are not covered under the Medicare program with the exception of EPO. *For a list of the drugs included in the composite rate see the Medicare Benefit Policy Manual (Pub. 100-2, Chapter 11, Section 30.4.1).*

50.3 - Required Information for In-Facility Claims Paid Under the Composite Rate

(Rev. 1084, Issued: 10-27-06; Effective: 04-01-07; Implementation: 04-02-07)

Form Locator (FL) 4 - Type of Bill Code Structure

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.

FL 6 - 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.

FLs 24, 25, 26, 27, 28, 29 and 30 - 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 - Patient is HMO Enrollee - Providers enter this code to indicate the patient is a member of an HMO.

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.

FLs 32, 33, 34 and 35 - 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 in FLs 39-41, if there is another payer involved.

Fields 32A-35A must be completed before fields 32B-35B are used.

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.

FL 36 - 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.*

FL 37 – Internal Control Number (ICN) 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 ICN/DCN of the claims to be adjusted. Payer A's ICN/DCN should be shown for line A of FL 37.

FLs 39, 40, and 41 - 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, except in FL 41. 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. There are four lines of data, line "A" through line "B." FLs 39A through 41A are used before FLs 39B through 41B (i.e., the first line is used up before the second line is used and so on).

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.

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.

FL 42 - 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

FL 44 - HCPCS/Rates

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

Modifiers are required for ESRD Billing for Adequacy of Hemodialysis. *For information on reporting the urea reduction ratio with modifiers G1 through G6, see section 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.

FL 45 – Service Date

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

FL 46 - Units of Service

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.

0635 - Erythropoietin (EPO) - Administrations, i.e., the number of times an injection of 10,000 units or more of EPO was administered.

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.

FL 47 - Total Charges

Hospital-based and independent renal facilities must complete this item. Hospital-based facilities show their customary charges that correspond to the appropriate revenue code in FL 42. 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 FL 42 as 0001 represents the total of all charges billed.

FL 67 – Principal Diagnosis Code

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

50.4 – Reserve for Future Use

50.5 - IPD in the Facility

(Rev. 1084, Issued: 10-27-06; Effective: 04-01-07; Implementation: 04-02-07)

Payment for IPD in the facility is subject to the same payment rules as hemodialysis.

50.8 - Training and Retraining

(Rev. 1084, Issued: 10-27-06; Effective: 04-01-07; Implementation: 04-02-07)

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	<i>\$12.00</i>
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:

$$\text{CAPD weekly rate} = 3 \times 130 = \$390$$

$$\text{CAPD daily rate} = \$390 \div 7 = \$55.71$$

$$\text{CAPD training rate} = \$130 + \$12 = \$142$$

$$6 \times 55.71 = \$334.26$$

$$+ \$142$$

$$\$476.26$$

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.

50.9 - Coding for Adequacy of Hemodialysis

(Rev. 1084, Issued: 10-27-06; Effective: 04-01-07; Implementation: 04-02-07)

A. General

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.

B. Billing Requirements

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.

60.1 - Lab Services

(Rev. 1084, Issued: 10-27-06; Effective: 04-01-07; Implementation: 04-02-07)

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. Independent dialysis facilities billing for separately billable laboratory tests that they perform must submit claims to the FI. Independent laboratories must bill the carrier.

Hospital-based laboratories providing separately billable laboratory services to hospital dialysis patients of the hospital's dialysis facility bill separately and are paid in accordance with the outpatient lab provisions. However, where the hospital lab does tests for an independent dialysis facility or for another hospital's facility, the non-patient billing provisions apply.

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.

60.2 - Drugs Furnished in Dialysis Facilities

(Rev. 1084, Issued: 10-27-06; Effective: 04-01-07; Implementation: 04-02-07)

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.100-2, 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.

60.2.1 - Billing Procedures for Drugs for Facilities

(Rev. 1084, Issued: 10-27-06; Effective: 04-01-07; Implementation: 04-02-07)

The following billing procedures apply to independent and hospital based facilities.

Facilities identify and bill for drugs by HCPCS code, along with revenue code 0636, “Drugs Requiring Specific Information.” Example below includes the HCPCS code and indicates the dosage amount specified in the descriptor of that code. Facilities use the units field as a multiplier to arrive at the dosage amount.

EXAMPLE:

HCPCS	Drug	Dosage (lowest denominator)	Amount
J3360	Valium	5 mg	\$2.00

Actual dosage, 10 mg

On the bill, the facility shows J3360 and 2 in the units field (2 x 5 mg = 10 mg). For independent facilities, FIs compare the price of \$4.00 (2 x \$2.00) to the billed charge and pay the lower, subject to coinsurance and deductible. *Effective January 1, 2006 payment is not subject to the lower of charges or fee. All separately payable drugs for both hospital-based and independent facilities are paid at ASP+6% except vaccines. For information on billing and payment for vaccines see section 60.6 of this chapter.*

NOTE: When the dosage amount is greater than the amount indicated for the HCPCS code, the facility rounds up to determine units. When the dosage amount is less than the amount indicated for the HCPCS code, use one as the unit of measure. In the example above, if the dosage were 7 mg, the facility would show 2 in the unit field, if the dosage were 3 mg, the facility would show 1 in the unit field.

Facilities bill for supplies used to administer drugs with revenue code 0270, “Medical/Surgical Supplies.” The number of administrations is shown in the units field.

EXAMPLE:

Revenue Code	Units
0270	3

The number of units for supply codes billed should match the number of injections billed on the claim form.

Appropriate HCPCS codes for administration-supply of separately billable drugs would include:

A4657: Injection Administration-supply Charge: include the cost of alcohol swab, syringe, and gloves.

A4913: IV Administration-supply Charge: include the cost of IV solution administration set, alcohol swab, syringe, and gloves. This code should only be used when an IV solution set is required for a drug to be given. This rate will not be paid for drugs that only require a syringe for administration.

60.4.3 - Payment Amount for Epoetin Alfa (EPO)

(Rev. 1084, Issued: 10-27-06; Effective: 04-01-07; Implementation: 04-02-07)

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
------	-------	------	-------

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 \times \$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.

EXAMPLE: $311 \times \$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 marrow 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 marrow 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.

60.6 - Vaccines Furnished to ESRD Patients

(Rev. 1084, Issued: 10-27-06; Effective: 04-01-07; Implementation: 04-02-07)

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.

70.1 - Method Selection for Home Dialysis Payment

(Rev. 1084, Issued: 10-27-06; Effective: 04-01-07; Implementation: 04-02-07)

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.

80.2.1 - Required Billing Information for Method I Claims

(Rev. 1084, Issued: 10-27-06; Effective: 04-01-07; Implementation: 04-02-07)

Method I claims require the same information as listed in §50.3 above with the following changes.

The FLs 24, 25, 26, 27, 28, 29 and 30. 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.

74 - Home - Providers enter this code to indicate the billing is for a patient who received dialysis services at home.

80 – Home Dialysis-Nursing Facility – Home dialysis furnished in a SNF or Nursing Facility.

80.3 - Calculating Payment for Intermittent Peritoneal Dialysis (IPD) for Method I Claims Submitted to the Intermediary

(Rev. 1084, Issued: 10-27-06; Effective: 04-01-07; Implementation: 04-02-07)

The value of a typical week of dialysis services generally serves as the maximum weekly payment; e.g., where, for nonmedical reasons, more frequent dialysis sessions of shorter duration are furnished.

While maintenance IPD is usually accomplished in sessions of 10-12 hours duration, three times per week, it is sometimes accomplished in fewer sessions of longer duration.

Regardless of the particular regimen used, under the composite rate IPD is paid based on a weekly equivalence of three composite rates per week.

80.3.1 - IPD at Home for Method I Claims Submitted to the Intermediary

(Rev. 1084, Issued: 10-27-06; Effective: 04-01-07; Implementation: 04-02-07)

IPD in the home is accomplished according to any one of several schedules. The total weekly dialysis time varies from 50 to 80 hours. For example, home IPD may be furnished everyday for 10 hours per day, every other day for 15 hours per dialysis day, every night for 8 hours per night, etc. Regardless of the particular regimen used, under the composite rate home IPD is paid based on a weekly equivalence of three composite rates per week.

Effective for claims with dates of service on or after April 1, 2007, line item billing is required for all dialysis sessions. For intermittent home dialysis under method one, the provider submits a separate line item for each dialysis session using the dates in the pre-determined plan of care and the units reported on each line should be one. In the event that the schedule was changed, the provider should note the changes in the medical record and bill according to the revised schedule.

80.4 - Calculating Payment for Continuous Ambulatory Peritoneal Dialysis (CAPD) and Continuous Cycling Peritoneal Dialysis (CCPD) Under the Composite Rate

(Rev. 1084, Issued: 10-27-06; Effective: 04-01-07; Implementation: 04-02-07)

CAPD and CCPD are furnished on a continuous basis, not in discrete sessions and, therefore, are paid on a weekly or daily basis, not on a per treatment basis. Billing instructions require providers to report the number of days in the units field. A facility's daily payment rate is 1/7 of three times the composite rate for a single hemodialysis treatment.

The equivalent weekly or daily IPD or CAPD/CCPD payment does not depend upon the number of exchanges of dialysate fluid per day (typically 3-5) or the actual number of days per week that the patient undergoes dialysis. The weekly (or daily) rate is based on the equivalency of one week of IPD or CAPD/CCPD to one week of hemodialysis, regardless of the actual number of dialysis days or exchanges in that week.

All home dialysis support services, equipment and supplies necessary for home IPD or CAPD/CCPD are included in the composite rate payment. No support services, equipment or supplies may be paid in addition to the composite rate.

Effective for claims with dates of service on or after April 1, 2007, line item billing is required for all dialysis sessions. For claims billing for Continuous Ambulatory Peritoneal Dialysis (CAPD) and Continuous Cycling Peritoneal Dialysis (CCPD), the provider may submit a separate dialysis line for each day of the month. If the provider is aware of an inpatient stay for the beneficiary within the month, the RDF may include the date of admission and date of discharge as a billable day for the dialysis but should omit the dates within the inpatient stay. In the event that the RDF is unaware of an inpatient stay during the month, the Medicare system shall detect the overlapping dates and reject only the line item dates within the inpatient stay but pay the remainder of the claim for any dates that are not within the inpatient stay.