

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2455	Date: April 26, 2012
	Change Request 7762

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

I. SUMMARY OF CHANGES: Hospitals have been billing CMS on a 12x claim for acute dialysis services (those not covered and paid under the end stage renal disease (ESRD) benefit in 42 CFR 413.174) furnished to hospital inpatients with ESRD, using HCPCS code G0257 (Unscheduled or emergency dialysis treatment for an ESRD patient in a hospital outpatient department that is not certified as an ESRD facility). While Medicare covers these services under the Outpatient Prospective Payment System, hospitals should instead be reporting them under HCPCS code 90935 (Hemodialysis procedure with single physician evaluation). G0257, by definition, is reserved for outpatients with ESRD and should be used only when the criteria specified in the Medicare Claims Processing Manual 100-04, Chapter 4, section 200.2 are met. Questions also have arisen regarding how hospitals should report dialysis for outpatients who do not have ESRD but who need hemodialysis treatment, so we are clarifying how those services should be billed.

EFFECTIVE DATE: October 1, 2012

IMPLEMENTATION DATE: October 1, 2012

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	4/Table of Contents
R	4/200.2 /Hospital Dialysis Services For Patients with and without End Stage Renal Disease (ESRD)

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):

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: 2455	Date: April 26, 2012	Change Request: 7762
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SUBJECT: Hospital Dialysis Services for Patients with and without End Stage Renal Disease (ESRD)

Effective Date: October 1, 2012

Implementation Date: October 1, 2012

I. GENERAL INFORMATION

A. Background: Hospitals have been billing CMS on a 12x claim for acute dialysis services (those not covered and paid under the end stage renal disease (ESRD) benefit in 42 CFR 413.174) furnished to hospital inpatients with ESRD, using HCPCS code G0257 (Unscheduled or emergency dialysis treatment for an ESRD patient in a hospital outpatient department that is not certified as an ESRD facility). While Medicare covers these services under the Outpatient Prospective Payment System, hospitals should instead be reporting them under HCPCS code 90935 (Hemodialysis procedure with single physician evaluation). G0257, by definition, is reserved for outpatients with ESRD and should be used only when the criteria specified in the Medicare Claims Processing Manual 100-04, Chapter 4, section 200.2 are met. Questions also have arisen regarding how hospitals should report dialysis for outpatients who do not have ESRD but who need hemodialysis treatment, so we are clarifying how those services should be billed.

B. Policy: Effective for services furnished on and after October 1, 2012, claims that are for a type of bill other than 13X (hospital outpatient) or 85X (critical access hospital) will be returned to the provider for correction if G0257 is reported on the claim. In these cases, either the hospital has reported the incorrect code for the service furnished or the hospital has reported the incorrect type of bill. In addition, CMS has revised section 200.2 of Chapter 4 of the Medicare Claims Processing Manual to clarify that HCPCS code 90935 (Hemodialysis procedure with single physician evaluation) may be reported and paid only if one of the following two conditions is met:

- 1) The patient is a hospital inpatient with or without ESRD and has no coverage under Part A, but has Part B coverage. The charge for hemodialysis is a charge for the use of a prosthetic device. See the Medicare Benefits Policy Manual, Pub.100-02, Chapter 15, section 120. A. The service must be reported on a type of bill 12X or type of bill 85X. See the Medicare Benefits Policy Manual, Pub. 100-02, Chapter 6, section 10 (Medical and Other Health Services Furnished to Inpatients of Participating Hospitals) for the criteria that must be met for services to be paid when a hospital inpatient has Part B coverage but does not have coverage under Part A; or
- 2) A hospital outpatient does not have ESRD and is receiving hemodialysis in the hospital outpatient department. The service is reported on a type of bill 13X or type of bill 85X.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)
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		A / B M A C	D M E M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
7762.1	The contractor shall install an edit that returns to the provider all claims on which G0257 is reported on a bill type that is not 13X or 85X.	X		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	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
						F I S S	M C S	V M S	C W F		
7762.2	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:

X-Ref Requirement Number	Recommendations or other supporting information:

X-Ref Requirement Number	Recommendations or other supporting information:
7762.1	Medicare Claims Processing Manual, Pub. 100-04, Chapter 4, section 200.2

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

V. CONTACTS

Pre-Implementation Contact(s): Ann Marshall: ann.marshall@cms.hhs.gov

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

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), 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):

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 4 - Part B Hospital

(Including Inpatient Hospital Part B and OPPS)

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(Rev.2455, Issued: 04-26-12)

200.2 –Hospital **Dialysis** Services For Patients with **and without** End Stage Renal Disease (ESRD)

200.2 –Hospital **Dialysis** Services For Patients **with and without** End Stage Renal Disease (ESRD)

(Rev. 2455, Issued: 04-26-12, Effective: 10-01-12, Implementation; 10-01-12)

Effective with claims with dates of service on or after August 1, 2000, hospital-based *End Stage Renal Disease* (ESRD) facilities must submit *services covered under the ESRD benefit in 42 CFR 413.174 (maintenance dialysis and those items and services directly related to dialysis such as drugs, supplies)* on a separate claim from services not *covered under the ESRD benefit*. Items and services not *covered under the ESRD benefit* must be billed by the hospital using the hospital bill type *and be paid under the Outpatient Prospective Payment System (OPPS) (or to a CAH at reasonable cost)*. *Services covered under the ESRD benefit in 42 CFR 413.174 must be billed on the ESRD bill type and must be paid under the ESRD PPS*. This requirement is necessary to properly pay *only* unrelated ESRD services (*those not covered under the ESRD benefit*) under OPPS (*or to a CAH at reasonable cost*).

Medicare does not allow payment for routine *or related* dialysis treatments, *which are covered and paid under the ESRD PPS, when* furnished to ESRD patients in the outpatient department of a hospital. However, in certain medical situations in which the ESRD *outpatient* cannot obtain her or his regularly scheduled dialysis treatment at a certified ESRD facility, the OPPS rule for 2003 allows payment for non-routine dialysis treatments (*which are not covered under the ESRD benefit*) furnished to ESRD *outpatients* in the outpatient department of a hospital. Payment *for* unscheduled dialysis *furnished to ESRD outpatients and paid under the OPPS is limited to* the following circumstances:

- Dialysis performed following or in connection with a dialysis-related procedure such as vascular access procedure or blood transfusions;
- Dialysis performed following treatment for an unrelated medical emergency; e.g., if a patient goes to the emergency room for chest pains and misses a regularly scheduled dialysis treatment that cannot be rescheduled, CMS allows the hospital to provide and bill Medicare for the dialysis treatment; or
- Emergency dialysis for ESRD patients who would otherwise have to be admitted as inpatients in order for the hospital to receive payment.

In these situations, non-ESRD certified hospital outpatient facilities are to bill Medicare using *the* Healthcare Common Procedure Coding System (HCPCS) code G0257 (Unscheduled or emergency *dialysis* treatment for an ESRD patient in a *hospital* outpatient department *that is not certified as an ESRD facility*).

HCPCS code G0257 may only be reported on type of bill 13X (hospital outpatient service) or type of bill 85X (critical access hospital) because HCPCS code G0257 only reports services for hospital outpatients with ESRD and only these bill types are used to report services to hospital

outpatients. Effective for services on and after October 1, 2012, claims containing HCPCS code G0257 will be returned to the provider for correction if G0257 is reported with a type of bill other than 13X or 85X (such as a 12x inpatient claim).

HCPCS code 90935 (Hemodialysis procedure with single physician evaluation) may be reported and paid only if one of the following two conditions is met:

- 1) The patient is a hospital inpatient with or without ESRD and has no coverage under Part A, but has Part B coverage. The charge for hemodialysis is a charge for the use of a prosthetic device. See Benefits Policy Manual 100-02 Chapter 15 section 120. A. The service must be reported on a type of bill 12X or type of bill 85X. See the Benefits Policy Manual 100-02 Chapter 6 section 10 (Medical and Other Health Services Furnished to Inpatients of Participating Hospitals) for the criteria that must be met for services to be paid when a hospital inpatient has Part B coverage but does not have coverage under Part A; or*
- 2) A hospital outpatient does not have ESRD and is receiving hemodialysis in the hospital outpatient department. The service is reported on a type of bill 13X or type of bill 85X.*

CPT code 90945 (Dialysis procedure other than hemodialysis (e.g. peritoneal dialysis, hemofiltration, or other continuous replacement therapies)), with single physician evaluation, may be reported by a hospital paid under the OPSS or CAH method I or method II on type of bill 12X, 13X or 85X.