Medicare Hospital Manual

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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REFER TO CHANGE REQUEST 1682

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents – ESRD Appendix	1 p.	1 p.
E405 – E410 (Cont.)	3 pp.	3 pp.

NEW/REVISED MATERIAL--*EFFECTIVE DATE:* October 1, 2001

Section E405, Billing for Intravenous Iron Therapy, is a new section, providing coverage, billing and payment instructions for Medicare coverage of iron sucrose injection as a first line treatment of iron deficiency anemia when furnished intravenously to patients undergoing chronic hemodialysis who are receiving supplemental erythropoeitin therapy.

Until a more specific HCPCS code is assigned, use J3490 to bill for iron sucrose injection.

This section is also revised to delete bill type 82X as an applicable bill type, correct the revenue code reporting and change the HCPCS reporting for sodium ferric gluconate complex in sucrose injection.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

ESRD APPENDIX - BILLING PROCEDURES

Inpatient Renal Services

Inpatient Billing

Billing for Dialysis Services

for medical necessity. Extra training sessions raise questions about either the adequacy of CAPD for the patient or the patient's capacity to learn or perform the CAPD technique. The patient's physician should address these questions in his explanation of the need for extra training sessions. The intermediary does not pay claims for more than 18 training sessions but forwards them to the HCFA regional office, which in turn sends them to the Bureau of Program Policy for decision. At the same time, the intermediary reports any facilities that consistently bill for excessive CAPD training sessions to the HCFA regional office so that it may determine if there are any problems with the facility's training program that require improvement. CAPD training is normally covered on an outpatient basis and when furnished to an inpatient, reimbursement is at the same rate as the facility's outpatient CAPD training rate.

C. Kidney Transplantation Services.--

1. Charge Structure Providers, Other (Describe).--Enter the appropriate standard charge for kidney acquisition in item 19T, Other. The standard charge for a living kidney donor or cadaveric kidney excision should be identified as "living donor kidney acquisition" or "cadaveric kidney acquisition" on a separate line. In addition, where the kidney was obtained from outside the hospital, identify in the Remarks section, item 30, the outside source by name and address. Enter the charges for services furnished the beneficiary in connection with a kidney transplant excluding kidney acquisition charges on the appropriate lines in item 19, as for any other surgical procedure. (See §400.1)

2. Kidney Acquisition.--An all inclusive rate/no charge structure hospital bills the standard kidney acquisition charge, in addition to the normal all inclusive charges for services rendered, directly to the Medicare recipient. If the hospital has an inclusive rate for all ancillary services, exclusive of routine services, show such inclusive rate separately from the kidney acquisition charge on line 19T as appropriate.

E404. BILLING FOR SERVICES WHEN A TRANSPLANT OCCURS

Complete the HCFA-1453 for the beneficiary who receives a kidney transplant from either a living or cadaveric donor according to §§400ff. Show in addition, the appropriate standard living donor or cadaveric kidney acquisition charge. Identify as "Living Donor Kidney Acquisition" or "Cadaveric Kidney Acquisition." Where interim bills are submitted, the acquisition charge appears on the billing form for the period during which the transplant took place. In addition to the standard kidney acquisition charge, bill the normal all-inclusive charges for services rendered directly to the Medicare recipient.

E405. BILLING FOR INTRAVENOUS IRON THERAPY

Iron deficiency is a common condition in end stage renal disease (ESRD) patients undergoing hemodialysis. Iron is a critical structural component of hemoglobin, a key protein found in normal red blood cells (RBCs) which transports oxygen. Without this important building block, anemic patients experience difficulty in restoring adequate, healthy RBC (hematocrit) levels. Clinical management of iron deficiency involves treating patients with iron replacement products while they undergo hemodialysis.

For claims with dates of service on or after December 1, 2000, sodium ferric gluconate complex in sucrose injection is covered by Medicare for first line treatment of iron deficiency anemia in patients undergoing chronic hemodialysis who are receiving supplemental erythropoeitin therapy. For claims with dates of service on or after October 1, 2001, Medicare also covers iron sucrose injection as a first line treatment of iron deficiency anemia when furnished intravenously to patients undergoing chronic hemodialysis who are receiving supplemental erythropoeitin therapy. Payment is made under the outpatient prospective payment system. Payment is made on a reasonable cost basis in critical access hospitals (CAHs). Deductible and coinsurance apply.

Bill on Form HCFA-1450 or electronic equivalent.

Applicable Bill Types.--The appropriate bill types are 13X, 72X, and 85X.

When utilizing the UB-92 flat file use record type 40 to report bill type. Record type (Field No. 1), sequence number (Field No. 2), patient control number (Field No. 3), and type of bill (Field No. 4) are required. When utilizing the hard copy UB-92 (Form HCFA-1450) report the applicable bill type in Form Locator (FL) 4 "Type of Bill." When utilizing the Medicare A 837 Health Care Claim version 3051 implementations 3A.01 and 1A.C1, report the applicable bill type in 2-130-CLM01, CLM05-01, and CLM05-03.

Revenue Code Reporting.--Report revenue code 636. When utilizing the UB-92 flat file use record type 61, Revenue Code (Field No. 5). When utilizing the hard copy UB-92 report the revenue code in FL 42 "Revenue Code." When utilizing the Medicare A 837 Health Care Claim version 3051 implementations 3A.01 and 1A.C1, report the applicable revenue code in 2-395-SV201.

HCPCS Reporting.--For claims with dates of service on or after December 1, 2000, report HCPCS code J3490 (Unclassified drugs) for sodium ferric gluconate complex in sucrose injection. For claims with dates of service on or after January 1, 2001, report HCPCS code J2915 for sodium ferric gluconate complex in sucrose injection. Until a specific code is developed for iron sucrose injection, report HCPCS code J3490 (Unclassified drugs). When utilizing the UB-92 flat file use record type 61, HCPCS code (Field No. 6) to report HCPCS code. When utilizing the hard copy UB-92 report the HCPCS code in FL 44 "HCPCS/Rates." When utilizing the Medicare A 837 Health Care Claim version 3041 implementations 3A.01 and 1A.C1, report the HCPCS/CPT in 2-395-SV202-02.

E406. BILLING FOR BLOOD AND TISSUE TYPING OF THE TRANSPLANT RECIPIENT WHETHER OR NOT MEDICARE ENTITLEMENT IS ESTABLISHED

Tissue typing and pre-transplant evaluation can only be reflected through the kidney acquisition charge of the hospital where the transplant will take place. The transplant hospital includes in its kidney acquisition cost center the reasonable charges it pays to the independent laboratory or other hospital which typed the potential transplant recipient, either before or after his entitlement. It also includes reasonable charges paid for physician tissue typing services, applicable to live donors and recipients (during the pre-entitlement period and after entitlement, but prior to hospital admission for transplantation).

E408. BILLING FOR BLOOD AND TISSUE TYPING AND OTHER PRE-TRANSPLANT EVALUATION OF LIVE DONORS

The entitlement date of the beneficiary who will receive the transplant is not a consideration in reimbursing for the services to donors, since no bill is submitted directly to Medicare. All charges for services to donors prior to admission into the hospital for excision are "billed" indirectly to Medicare through the live donor acquisition charge of transplanting hospitals.

E410. BILLING DONOR AND RECIPIENT PRE-TRANSPLANT SERVICES (PERFORMED BY TRANSPLANT HOSPITALS OR OTHER PROVIDERS) TO THE KIDNEY ACQUISITION COST CENTER

A. The transplant hospital prepares an itemized statement of the services rendered for submittal to its cost accounting department. Regular Medicare billing forms (HCFA-1453 or 1483) are not necessary for this purpose, since no bills are submitted to the intermediary at this point.

B. The itemized statement should contain information that identifies the person receiving the service (donor/recipient), the service rendered and the charge for the service, as well as a statement as to whether this is a potential transplant donor or recipient. If it is a potential donor, identify the prospective recipient.

Example: Mary Jones
200 Adams St.
Anywhere, MS

Transplant donor evaluation services for recipient:

John Jones
200 Adams St.
Anywhere, MS

C. Services performed in a hospital other than the potential transplant hospital or by an independent laboratory are billed by that facility to the potential transplant hospital. This holds true regardless of where in the United States the service is performed. For example, if the donor services are performed in a Florida hospital and the transplant is to take place in a California hospital, the Florida hospital bills the California hospital (as described in (B) above). The Florida hospital is paid by the California hospital which recoups the monies through the kidney acquisition cost center.