ESRD Billing

ESRD Billing Considerations

Objective

This chapter will provide any ESRD billing changes directly stated or implied implicitly in the final rule so that ESRD facilities and FIs can adjust claim processing techniques to accommodate the 2005 updates. This will ensure that ESRD facilities submit claims correctly and that FIs will pay claims correctly.

Participants will learn the following information during the course of this chapter:

- ESRD billing requirements
- Timeline and future changes
- Resources

Billing

Form Locator (FL) 4 - Type of Bill (Required)
The first two digits, 72, indicate a claim for an ESRD facility. The third digit identifies the frequency of the claim being submitted.

Bill Type	Definition
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 health insurance claim numbers (HICNs), duplicate payments and some OIG recoveries. For incorrect provider numbers or HICNs, a corrected bill is also submitted using a code 721.

Form Locator 6 - Statement Covers Period (From-Through) - Hospital-based and independent renal dialysis facilities:
Show the dates during which the patient's care was under the supervision of the facility. Exclude dates when the patient's care was under the supervision of another entity (e.g., hospital, another ESRD facility, skilled nursing facility (SNF)).

Form Locators 24 - 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).

Condition Code	Definition
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.
74	Home – Providers enter this code to indicate the billing is for a patient who received dialysis services at home.
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.
80	Home Dialysis in Nursing Facility (NF) – Beneficiary receives home dialysis in NF including SNF. (Effective 3/3/05.)

Form Locators 32 - 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.

Occurrence Code	Definition
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 employer group health plan (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.

Form Locator 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.

Occurrence Span Code	Definition
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.

Form Locator 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.

Form Locators 39 - 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 - 41A are used before FLs 39B - 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.):

Value Code	Definition
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. If 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 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.
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.
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.)
68	EPO 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.
A8	Weight of Patient - Code indicates the weight of the patient in kilograms. The weight of the patient should be measured after dialysis during the last dialysis session of the month. (Effective 3/3/05.)
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. (Effective 3/3/05.)

Form Locator 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.

Revenue Code	Definition
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

Revenue Code	Definition
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

Revenue Code	Definition
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

Revenue Code	Definition
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

Form Locator 44 - HCPCS/Rates
When a revenue code in the 083X series (peritoneal dialysis) is placed in FL 42, an entry must also appear in FL 44. This entry identifies the duration (number of hours) of the peritoneal treatments. Peritoneal dialysis is usually done in sessions of 10-24 hours duration seven days a week, and each session is billed and paid as one treatment. Providers enter the number of hours for each session in Value Code 67. They also enter the number of sessions (treatments) in FL 46.

Peritoneal dialysis sessions of between 20-29 hours duration is paid as 1 1/2 treatments. However, for purposes of billing, fractions or decimals are not acceptable. The number of treatments is rounded upwards, e.g., 1 1/2 treatments are equal to two. The total number of treatments is placed in FL 46. The number of hours for each treatment is entered in FL 44 so that proper payment may be made.

Extended peritoneal dialysis sessions of 30 hours or more, given once a week, in place of two or three sessions of shorter duration are billed and paid as three treatments. Providers enter the number of hours for each session in FL 44. They also enter the number of treatments in FL 46.

Modifiers are required for ESRD Billing for Adequacy of Hemodialysis. ESRD facilities should report information about the range of urea reduction ratio (URR) values through the use of a G modifier attached to the CPT

code 90999 in FL 44 of the UB-92. The CPT code and modifier are required for dialysis reported through UB-92 revenue codes 0820, 0821, and 0829.

Modifier	Definition
G1	Most recent URR of less than 60%
G2	Most recent URR of 60% to 64%
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
G6	ERSD patient for whom less than seven dialysis sessions have been provided in a month

Form Locator 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:

Revenue Code	Units Defined
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

Form Locator 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. 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 000l represents the total of all charges billed.

ESRD Name Address Telephone Number	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
			721

5 FED. TAX NO.	6 STATEMENT COVERS FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	01/01/05	01/31/05					

12 PATIENT NAME	13 PATIENT ADDRESS
Medicare Beneficiary's Name	123 XXX, City, State Zip Code

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
05111930	M									74							

32 OCCURRENCE CODE	DATE	33 CODE	OCCURRENCE DATE	34 CODE	OCCURRENCE DATE	35 CODE	OCCURRENCE DATE	36 CODE	OCCURRENCE SPAN FROM	THROUGH	37
											A
											B
											C

38

Value code A8 reports weight in kilograms and A9 reports height in centimeters.

39 VALUE CODE CODE	AMOUNT		40 VALUE CODES CODE	AMOUNT		41 VALUE CODES CODE	AMOUNT	
a A8	68	04	A9	165	1	48	10	2
b 68	31060							
c								
d								

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES		49
0270	Supplies	A4657	010105	12	6	00			
0634	EPO administration less than 10,000 units	Q4055	010105	12	311	00			
0851	CCPD	90921	010105	31	1641	76			
0001	Total				1958	76			

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
Medicare	xx-xxxx	Y	Y			

57 *DUE FROM PATIENT*

58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
Medicare Beneficiary's Name	01	Beneficiary's Medicare Number		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

Co-morbid conditions are reported

67 PRIN.DIAG.CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG.	77 E-CODE	78
585	280.9	250.1	401.9								

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID DOCTOR'S NAME AND UPIN
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID

84 REMARKS

CCPD CLAIM EXAMPLE

OTHER PHY

85 PROVIDER REPRESENTATIVE X — 86 DATE

UB-92 HCFA-1450

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART

Miscellaneous Billing Issues

FIs must:

- Accept HCPCS code A4657 with Revenue Code 270 for injection supplies used in the administration of EPO in all Renal Dialysis Facilities (RDF).
- Instruct providers to utilize CC 59 when ESRD beneficiaries receive dialysis services at a facility that is not the beneficiary's home facility.
- Instruct the non-home facility providing dialysis services to utilize CC 59 on the Type of Bill (TOB) 72X in conjunction with the appropriate setting CCs.
- Instruct RDFs to utilize CC 80 when an ESRD beneficiary receives Home Dialysis in NFs including SNFs.
- Instruct RDFs to continue to use CC74 when an ESRD beneficiary receives Home Dialysis in NFs including SNFs.
- CC 74 should always be used with CC 80.

Timeline and Future Changes

- March 7, 2005, providers must report new value codes and composite rate adjustments take effect.
- On April 1, 2005, the case-mix adjustments will take effect.
- A proposed rule in mid-2005 will be published to address payment changes for 2006.

The MMA requires the establishment of a demonstration to test the revised payment system over a 3-year period beginning January 1, 2006.

Resources

Centers for Medicare & Medicaid Services
End Stage Renal Disease Information Resource Page
http://www.cms.hhs.gov/providers/esrd.asp

Centers for Medicare & Medicaid Services
ESRD Composite Payment Rate System Program Transmittals

- Change Request 3539 / Transmittal 348

http://www.cms.hhs.gov/manuals/pm_trans/R348CP.pdf

- Change Request 3554 / Transmittal 27

http://www.cms.hhs.gov/manuals/pm_trans/R27BP.pdf

- Change Request 3554 / Transmittal 373

http://www.cms.hhs.gov/manuals/pm_trans/R373CP.pdf

- Change Request 3720 / Transmittal 477

http://www.cms.hhs.gov/manuals/pm_trans/R477CP.pdf

Centers for Medicare & Medicaid Services
Medicare Part B Drugs Average Sales Price Information Resource
http://www.cms.hhs.gov/providers/drugs/asp.asp

Centers for Medicare & Medicaid Services
Medicare Learning Network
http://www.cms.hhs.gov/medlearn

Centers for Medicare & Medicaid Services
Medlearn Matters...Information for Medicare Providers
http://www.cms.hhs.gov/medlearn/matters

Centers for Medicare & Medicaid Services
Medicare Prescription Drug, Improvement and Modernization Act of 2003
Information
http://www.cms.hhs.gov/medicarereform

Federal Register
Payment for Renal Dialysis Services Final Rule
Vol. 69, No. 219, November 15, 2004
http://a257.g.akamaitech.net/7/257/2422/15nov20040800/edocket.access.gpo.gov/2004/pdf/04-24758.pdf