

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1456	Date: February 22, 2008
	Change Request 5931

Subject: MANUALIZATION of Payment for Outpatient ESRD-Related Services

I. SUMMARY OF CHANGES: In the calendar year 2004 and 2005 physician fee schedule-final rules, CMS made changes to the way physicians and practitioners are paid for managing patients on dialysis. Chapter 8, section 140 has been revised to manualize these changes. Information is also being re-organized. For example, information previously contained in sections 140.1 and 140.2 has been moved to section 140. Additionally, the title of section 140.1 has been changed to "Payment for ESRD-Related Services Under the Monthly Capitation Payment (Center Based Patients)". The title of section 140.2 has been changed to "Payment for ESRD-Related Services (Per Diem)".

New / Revised Material

Effective Date: March 24, 2008

Implementation Date: March 24, 2008

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	8/140/Monthly Capitation Payment Method for Physicians" Services Furnished to Patients on Maintenance Dialysis
R	8/140.1/Payment for ESRD-Related Services Under the Monthly Capitation Payment (Center Based Patients)
N	8/140.1.1/Payment for Managing Patients on Home Dialysis
N	8/140.1.2/Patients Who Switch Modalities (Center to Home and Vice Versa)
R	8/140.2/Payment for ESRD-Related Services (Per Diem)
N	8/140.2.1/Guidelines for physician or practitioner billing (Per Diem)
R	8/140.3/Data Required on Claim for Monthly Capitation Payment
R	8/140.4/Controlling Claims Paid Under the Monthly Capitation

	Payment Method
D	8/140.5/Determining Monthly Capitation Payment Amount for Physician's Services to Maintenance Dialysis Patients
D	8/140.5.1/Temporary Absence Under MCP

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:

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

SECTION B: For Medicare Administrative Contractors (MACs):

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: 1456	Date: February 22, 2008	Change Request: 5931
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SUBJECT: MANUALIZATION of Payment for Outpatient ESRD Related Services

Effective Date: March 24, 2008

Implementation Date: March 24, 2008

I. GENERAL INFORMATION

A. Background: In the Federal Register published November 7, 2003, (68 FR 63216) CMS established new G codes for managing patients on dialysis with monthly capitation payments (MCP) varying based on the age of the beneficiary and number of visits provided within each month. Under this methodology, separate codes are billed for providing one visit per month, two to three visits per month and four or more visits per month. The lowest payment amount applies when a physician provides one visit per month; a higher payment is provided for two to three visits per month. To receive the highest payment amount, a physician would have to provide at least four end stage renal disease (ESRD) related visits per month. The G codes are reported once per month for services performed in an outpatient setting that are related to the patients' ESRD. CMS also established separate G codes for home dialysis patients based on the age of the beneficiary.

CMS published an instruction on September 17, 2004 (CR 3414, "Payment for Outpatient ESRD-Related Services", Transmittal 300). This one time notification provided interim instructions regarding billing for specific less than full month ESRD-related scenarios (e.g. transient patients) and visits furnished to patients in hospital observation status. Physicians and practitioners were instructed to use the unlisted dialysis procedure code, as identified by CPT code 90999 to bill for specific ESRD related scenarios (less than full month) and visits furnished when the beneficiary is designated as hospital observation status.

Subsequently, in the Federal Register published November 15, 2004, (69 FR 66357) CMS changed the descriptor of the G codes for ESRD-related home dialysis services, less than full month, as identified by G0324 through G0327 to allow other partial month scenarios, in addition to patients dialyzing at home. We also establish policy that permits visits furnished to beneficiaries in hospital observation status to be counted for purposes of billing the MCP service.

CMS published a one time notification December 23, 2004 (CR3595, "Emergency Update to the CY 2005 Physician Fee Schedule Data Base", Transmittal 414). This one time notification included descriptors of G0324-G0327 to allow these codes to be used for other scenarios in addition to home dialysis less than full month,(e.g. transient patients, partial month due to hospitalization, transplant or when the patient expired, and when a permanent change in MCP physician occurs during the month).

NOTE: ESRD-related services as described by HCPCS codes G0308 - G0327 are already included as part of the HCPCS payment file. Medicare contractors are currently making payment for these service codes.

B. Policy: ESRD related services per full month as described by CPT codes 90918-90921 and ESRD related services (less than full month) as described by CPT codes 90922-90925 are no longer valid for Medicare. CPT codes 90918 – 90925 were replaced by HCPCS codes G0308 – G0327.

ESRD related services per full month as described by HCPCS codes G0308-G0319 are used to bill for the monthly capitation payment (MCP) service for beneficiaries who dialyze in a dialysis center or other outpatient facility. The appropriate MCP service code is based on the age of the beneficiary and number of visits furnished during the month.

ESRD-related patient visits must be furnished face to face by a physician, clinical nurse specialist, nurse practitioner, or physician's assistant. The MCP physician or practitioner may use other Medicare certified physicians or practitioners to provide some of the visits during the month. However, the non-MCP physician or practitioner must be a partner, employees of the same group practice or an employee of the MCP physician or practitioner, for example, the physician or practitioner furnishing visits under the MCP is either a W-2 employee or 1099 independent contractor. In this situation, the physician or practitioner who provides the complete assessment, establishes the patient's plan of care and provides the ongoing management should be the physician or practitioner who submits the bill for the monthly service.

Telehealth

ESRD-related services with 2 or 3 visits per month and ESRD-related visits with 4 or more visits per month may be furnished as a telehealth service. However, at least one visit per month must be furnished face-to-face "hands on" to examine the access site by a physician, clinical nurse specialist, nurse practitioner, or physician's assistant. Instructions regarding how ESRD-related visits may be furnished as a Medicare telehealth service are located in publication 100-02, Medicare Benefit Policy Manual, chapter 15, section 270 and publication 100-04, Medicare Claims Processing Manual, chapter 12, section 190.

Home Dialysis

HCPCS codes G0320 – G0323 are used to bill for the ongoing management of home dialysis patients per full month. If a home dialysis patient receives dialysis in a dialysis center or other facility during the month (or vice versa), the physician or practitioner is paid the management fee for the home dialysis patient and should not bill the codes in the range of G0308 through G0319. This situation should be coded using the ESRD-related services G codes for a home dialysis patient per full month (G0320 - G0323).

Physicians and practitioners should use the ESRD-related services G codes for a home dialysis patient per full month for patients that switch modalities regardless of whether the ESRD beneficiary went from home dialysis to center-based dialysis, or vice versa, and regardless of the proportion of the month that the beneficiary was receiving each modality.

Example #1. A 70 year-old ESRD beneficiary dialyzes at home for the first 10 days of the month and at a dialysis center for the remaining 20 days. The MCP physician should bill HCPCS code G0323.

Example #2. A 70 year-old ESRD beneficiary dialyzes at a dialysis center for the first 10 days of the month and at home for the remaining 20 days. The MCP physician should bill HCPCS code G0323.

Patients Designated as Hospital Observation Status

ESRD-related visits furnished by the MCP physician or practitioner to patients designated as hospital observation status should be counted for purposes of billing the MCP service. The unlisted dialysis procedure as described by CPT code 90999, should not be used for billing ESRD-related visits furnished to a beneficiary designated as hospital observation status.

Per Diem Scenarios

HCPCS codes G0324 – G0327 should be used to bill for specific scenarios as discussed in the attached manual instructions (see section 140.2). These scenarios are described below.

- Home dialysis patients (less than full month);
- Transient patients – Patients traveling away from home (less than full month);
- Partial month where there was one or more face-to-face visits without a complete assessment of the patient and the patient was either hospitalized before a complete assessment was furnished, dialysis stopped due to death, or the patient had a transplant.
- Patients who have a permanent change in their MCP physician during the month.

The per diem codes as described by G0324 through G0327 should only be used for these circumstances. The per diem codes may not be used for a full month when the complete monthly assessment is not furnished. The unlisted dialysis procedure as described by CPT code 90999, should not be used for billing ESRD-related services less than full month as discussed above.

Moved Information

Information previously contained in sections 140.1 (Services Included in MCP) and 140.2 (Services Excluded From MCP) were merged into a revised section 140 (MCP Method for Physicians’ Services Furnished to Patients on Maintenance Dialysis). The title of section 140.1 has been changed to “Payment for ESRD-Related Services Under the Monthly Capitation Payment (Center Based Patients)”. The title of section 140.2 has been changed to “Payment for ESRD-Related Services (Per Diem)”.

Deleted Sections

Sections 140.5, (Determining MCP Amount for Physician’s Service to Maintenance Dialysis Patients) and 140.51 (Temporary Absence Under MCP) were deleted from chapter 8 as these sections are superseded by the new instructions. For example, section 140.1 discusses the appropriate ESRD-related service codes by age and number of monthly visits. Section 140.1(d) discusses qualifying visits and the use of additional practitioners (other than the MCP physician or practitioner) to furnish visits under the MCP. Section 140.2 addresses the per diem payment method.

II. BUSINESS REQUIREMENTS TABLE

Use “Shall” to denote a mandatory requirement

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 I	Shared-System Maintainers				OTHER
						F I S S	M C S	V M S	C W F		
5931.1	Local part B carriers and or A/B MACs shall pay for ESRD related services based on the appropriate physician or practitioner fee schedule for HCPCS codes G0308 –	X			X						

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 I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	G0327.										

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 I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
5931.2	<p>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.</p> <p>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.</p>	X			X						

IV. SUPPORTING INFORMATION

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

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Policy: Craig Dobyski; Craig.Dobyski@cms.hhs.gov; 410-786-4584.
 Claims Processing: Rhem Gray; Rhem.Gray@cms.hhs.gov; 410-786-6986
 or Melvia Page-Lasowski; Melvia.Pagelasowski@cms.hhs.gov; 410-786-4727.

Post-Implementation Contact(s):

Appropriate Regional Office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Carriers (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 8 - Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims

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140.1.1 - *Payment for Managing Patients on Home Dialysis*

140.1.2 - *Patients That Switch Modalities (Center to Home and Vice Versa)*

140.2 - *Payment for ESRD-Related Services (Per Diem)*

140.2.1 - *Guidelines for Physician or Practitioner Billing (Per Diem)*

140 - Monthly Capitation Payment Method for Physicians' Services Furnished to Patients on Maintenance Dialysis

(Rev.1456, Issued: 02-22-08, Effective: 03-24-08, Implementation: 03-24-08)

Physicians and practitioners managing patients on dialysis (center based) are paid a monthly capitation payment (MCP) for most outpatient dialysis-related physician services furnished to a Medicare end stage renal disease (ESRD) beneficiary. The payment amount varies based on the number of visits provided within each month and the age of the ESRD beneficiary. Physicians and practitioners managing ESRD patients who dialyze at home are paid a single monthly rate based on the age of the ESRD beneficiary, regardless of the number of face-to-face physician or practitioner visits. The MCP is reported once per month for services performed in an outpatient setting that are related to the patients' ESRD.

Physicians and practitioners may receive payment for managing patients on dialysis for less than a full month of care in specific circumstances as discussed in section 140.2. Payment for ESRD related services, less than a full month, is made on a per diem bases.

Payment for ESRD-related services is made at 80 percent of the Medicare approved amount (lesser of the actual charge or applicable Medicare fee schedule amount) after the beneficiary's Part B deductible is met. The beneficiary is responsible for the Part B deductible and the 20 percent coinsurance for physician and practitioner ESRD-related services.

A. Services Included in Monthly Capitation Payment

The following physician services are included in the MCP:

- Assessment of the need for a specified diet and the need for nutritional supplementation for the control of chronic renal failure. Specification of the quantity of total protein, high biologic protein, sodium, potassium, and amount of fluids to be allowed during a given time period. For diabetic patients with chronic renal failure, the prescription usually specifies the number of calories in the diet.
- Assessment of which mode(s) of chronic dialysis (types of hemodialysis or peritoneal dialysis) are suitable for a given patient and recommendation of the type(s) of therapy for a given patient.
- Assessment and determination of which type of dialysis access is best suited for a given patient and arrangement for creation of dialysis access.
- Assessment of whether the patient meets preliminary criteria as a renal transplant candidate and presentation of this assessment to the patient and family.
- Prescription of the parameters of intradialytic management. For chronic hemodialysis therapies, this includes the type of dialysis access, the type and

amount of anticoagulant to be employed, blood flow rates, dialysate flow rate, ultrafiltration rate, dialysate temperature, type of dialysate (acetate versus bicarbonate) and composition of the electrolytes in the dialysate, size of hemodialyzer (surface area) and composition of the dialyzer membrane (conventional versus high flux), duration and frequency of treatments, the type and frequency of measuring indices of clearance, and intradialytic medications to be administered. For chronic peritoneal dialysis therapies, this includes the type of peritoneal dialysis, the volume of dialysate, concentration of dextrose in the dialysate, electrolyte composition of the dialysate, duration of each exchange, and addition of medication to the dialysate, such as heparin, and the type and frequency of measuring indices of clearance. For diabetics, the quantity of insulin to be added to each exchange is prescribed.

- Assessment of whether the patient has significant renal failure-related anemia, determination of the etiology(ies) for the anemia based on diagnostic tests, and prescription of therapy for correction of the anemia, such as vitamins, oral or parenteral iron, and hormonal therapy such as erythropoietin.
- Assessment of whether the patient has hyperparathyroidism and/or renal osteodystrophy secondary to chronic renal failure and prescription of appropriate therapy, such as calcium and phosphate binders for control of hyperphosphatemia. Based upon assessment of parathormone levels, serum calcium levels, and evaluation for the presence of metabolic bone disease, the physician determines whether oral or parenteral therapy with vitamin D or its analogs is indicated and prescribes the appropriate therapy. Based upon assessment and diagnosis of bone disease, the physician may prescribe specific chelation therapy with deferoxamine and the use of hemoperfusion for removal of aluminum and the chelation.
- Assessment of whether the patient has dialysis-related arthropathy or neuropathy and adjustment of the patient's prescription accordingly. Referral of the patient for any additional needed specialist evaluation and management of these end-organ problems.
- Assessment of whether the patient has fluid overload resulting from renal failure and establishment of an estimated "ideal (dry) weight." The physician determines the need for fluid removal independent of the dialysis prescription and implements these measures when indicated.
- Determination of the need for and prescription of antihypertensive medications and their timing relative to dialysis when the patient is hypertensive in spite of correction of fluid overload.
- Periodic review of the dialysis records to ascertain whether the patient is receiving the prescribed amount of dialysis and ordering of indices of clearance, such as urea kinetics, in order to ascertain whether the dialysis prescription is producing adequate dialysis. If the indices of clearance suggest that the prescription requires alteration, the physician orders changes in the hemodialysis prescription, such as

blood flow rate, dialyzer surface area, dialysis frequency, and/or dialysis duration (length of treatment). For peritoneal dialysis patients, the physician may order changes in the volume of dialysate, dextrose concentration of the dialysate, and duration of the exchanges.

- Periodic visits (*at least one per month*) to the patient during dialysis to ascertain whether the dialysis is working well and whether the patient is tolerating the procedure well (physiologically and psychologically). During these visits, the physician determines whether alteration in any aspect of a given patient's prescription is indicated, such as changes in the estimate of the patient's dry weight. Review of the treatment with the nurse or technician performing the therapy is also included. The frequency of these visits will vary depending upon the patient's medical status, complicating conditions, and other determinants.
- Performance of periodic physical assessments, based upon the patient's clinical stability, in order to determine the necessity for alterations in various aspects of the patient's prescription. Similarly, the physician reviews the results of periodic laboratory testing in order to determine the need for alterations in the patient's prescription, such as changes in the amount and timing of phosphate binders or dose of erythropoietin.
- Periodic assessment of the adequacy and function of the patient's dialysis access appropriate tests and antibiotic therapy.
- Interpretations of the following tests:
 - o Bone mineral density studies (CPT codes 76070, 76075, 78350, and 78351);
 - o Noninvasive vascular diagnostic studies of hemodialysis access (CPT codes 93925, 93926, 93930, 93931, and 93990);
 - o Nerve conduction studies (CPT codes 95900, 95903, 95904, 95925, 95926, 95927, 95934, 95935, and 95936);
 - o Electromyography studies (CPT codes 95860, 95861, 95863, 95864, 95867, 95867, 95869, and 95872).
- Periodic review and update of the patient's short-term and long-term care plans with staff.
- Coordination and direction of the care of patients by other professional staff, such as dietitians and social workers.
- Certification of the need for items and services such as durable medical equipment and home health care services. Care plan oversight services described by CPT code 99375 are included in the MCP and may not be separately reported.

B. Services Excluded from Monthly Capitation Payment

The following physician services furnished to the physician's ESRD patients are excluded from the MCP and should be paid in accordance with the physician fee schedule:

1. Administration of hepatitis B vaccine.
2. Surgical services such as:
 - Temporary or permanent hemodialysis catheter placement;
 - Temporary or permanent peritoneal dialysis catheter placement;
 - Repair of existing dialysis accesses;
 - Placement of catheter(s) for thrombolytic therapy;
 - Thrombolytic therapy (systemic, regional, or access catheter only; hemodialysis or peritoneal dialysis);
 - Thrombectomy of clotted cannula;
 - Arthrocentesis;
 - Bone marrow aspiration; and
 - Bone marrow biopsy.
3. Interpretation of tests that have a professional component such as:
 - Electrocardiograms (12 lead, Holter monitor, stress tests, etc.);
 - Echocardiograms;
 - 24-hour blood pressure monitor;
 - Biopsies; and
 - Spirometry and complete pulmonary function tests.
4. Complete evaluation for renal transplantation. While the physician assessment of whether the patient meets preliminary criteria as a renal transplant candidate is included under the MCP, the complete evaluation for renal transplantation is excluded from the MCP
5. Evaluation of potential living transplant donors.

6. The training of patients to perform home hemodialysis, self hemodialysis, and the various forms of self peritoneal dialysis.
7. Non-renal related physician's services. These services may be furnished by the physician providing renal care or by another physician. They may not be incidental to services furnished during a dialysis session or office visit necessitated by the renal condition. The physician must provide documentation that the illness is not related to the renal condition and that the added visits are required. The contractor's medical staff determines whether additional reimbursement is warranted for treatment of the unrelated illness. For example, the medical management of diabetes mellitus that is not related to the dialysis or furnished during a dialysis session is excluded.
8. Covered physician services furnished to hospital inpatients.
9. All physician services that antedate the initiation of outpatient dialysis.
10. Covered physician services furnished by another physician when the patient is not available to receive the outpatient services as usual; for example, when the patient is traveling out of town.

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

(Rev.1456, Issued: 02-22-08, Effective: 03-24-08, Implementation: 03-24-08)

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

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

a. Month defined.

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

b. Determination of the age of beneficiary.

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

c. Qualifying Visits Under the MCP

- *General policy.*

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

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

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

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

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

- *Residents, interns and fellows.*

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

- *Patients designated/admitted as hospital observation status.*

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

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

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

- *SNF residents admitted as an inpatient.*

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

- *ESRD Related Visits as a Telehealth Service.*

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

140.1.1 Payment for Managing Patients on Home Dialysis

(Rev.1456, Issued: 02-22-08, Effective: 03-24-08, Implementation: 03-24-08)

Physicians and practitioners managing ESRD patients who dialyze at home are paid a single monthly rate based on the age of the beneficiary, regardless of the number of face-to-face physician or practitioner visits. A frequency of required visits does not apply to patients on home dialysis. The management of home dialysis patients who remain a home dialysis patient the entire month should be coded using the ESRD-related services for home dialysis patients HCPCS codes.

140.1.2 Patients Who Switch Modalities (Center to Home and Vice Versa)

(Rev.1456, Issued: 02-22-08, Effective: 03-24-08, Implementation: 03-24-08)

If a home dialysis patient receives dialysis in a dialysis center or other outpatient facility during the month, the MCP physician or practitioner is paid the management fee for the home dialysis patient and cannot bill the ESRD-related services codes for managing center based patients.

This situation should be coded using the ESRD–related services G codes for a home dialysis patient per full month. Physicians and practitioners should use the ESRD–related services G codes for a home dialysis patient per full month when billing for outpatient ESRD-related services when a home dialysis patient receives dialysis in a dialysis center or other outpatient facility during the month.

Physicians and practitioners should use the ESRD–related services G codes for a home dialysis patient per full month for patients that switch modalities regardless of whether the ESRD beneficiary went from home dialysis to center-based dialysis, or vice versa, and regardless of the proportion of the month that the beneficiary was receiving each modality.

140.2 Payment for ESRD-related services (Per Diem)

(Rev.1456, Issued: 02-22-08, Effective: 03-24-08, Implementation: 03-24-08)

Physicians and practitioners may receive payment for managing patients on dialysis for less than a full month of care in specific circumstances as discussed in this section. Payment for ESRD related services, less than a full month, is paid on a per diem basis.

Per diem ESRD-related services should be coded using the ESRD related services (less than full month), per day HCPCS codes for ESRD-related services furnished in the situations described below.

- *Home dialysis patients (less than full month);*
- *Transient patients – Patients traveling away from home (less than full month);*
- *Partial month where there was one or more face-to-face visits without a complete assessment of the patient and the patient was either hospitalized before a complete assessment was furnished, dialysis stopped due to death, or the patient had a transplant.*
- *Patients who have a permanent change in their MCP physician during the month.*

The ESRD-related services (less than full month), per day HCPCS codes should only be used for the circumstances described above. The per diem codes may not be used for a full month when a complete monthly assessment is not furnished.

140.2.1 Guidelines for physician or practitioner billing-- (Per Diem)

(Rev.1456, Issued: 02-22-08, Effective: 03-24-08, Implementation: 03-24-08)

A. Home dialysis, transient patient and partial month

When submitting claims for ESRD-related services (less than full month) per day, the physician or practitioner should specify the number of days he or she was responsible for the beneficiary's outpatient ESRD-related services during the month.

Only one code should be used to report the daily management of home dialysis patients, transient patients, and for partial month scenarios. For example, if a home dialysis patient receives dialysis at home for two weeks and is hospitalized for the remainder of the month, then 14 units of the age appropriate ESRD-related per day code is billed. The MCP service is not billed.

For transient patients, the physician or practitioner responsible for the transient patient's ESRD-related care should bill the appropriate ESRD-related services, per day code. Only the physician or practitioner responsible for the traveling ESRD patient's care is permitted to bill for ESRD-related services using the per diem ESRD-related services HCPCS codes.

For partial month scenarios resulting from hospitalization, kidney transplant, or the patient expired, if the MCP physician or practitioner furnished a complete monthly assessment of the patient, he or she should bill using the age appropriate MCP service that reflects the number of visits furnished during the month.

Example #1: An ESRD beneficiary was hospitalized on the tenth through the twentieth day of the month. On the third day of the month, the MCP physician or practitioner furnished a face-to-face visit including a complete assessment and a subsequent outpatient visit on the twenty-fifth day of the month. While the patient was hospitalized, an inpatient ESRD-related visit was furnished.

In this scenario, the MCP physician or practitioner may bill for the appropriate outpatient MCP service based on the age of the beneficiary and number of visits furnished during the month. The physician or practitioner who furnished the inpatient visit may bill for the appropriate inpatient ESRD-related service code.

Example #2: An ESRD beneficiary vacationing in Florida is away from his or her home dialysis site from August fifteenth through September seventh. On August tenth, the MCP physician furnishes a face-to-face visit. For the month of September, the MCP physician furnishes a visit on the ninth and a subsequent visit on the twenty-fifth of the month. A physician in Florida is responsible for the beneficiary's ESRD-related care from August fifteenth through September seventh.

In this scenario, the physician or practitioner responsible for the transient patient's ESRD-related care bills sixteen units of the age appropriate ESRD-related services for dialysis less than full month, per day code for the month of August and seven units of the per day code for the month of September. The MCP physician bills the MCP service with

one visit for the month of August and the MCP service with two to three visits for the month of September.

If the transient beneficiary is under the care of a physician or practitioner other than his or her regular MCP physician for an entire calendar month, the physician or practitioner responsible for the transient patient's ESRD-related care must furnish a complete assessment and bill for ESRD-related services under the MCP.

B. Patient has a permanent change in their MCP physician during the month

ESRD-related services (less than full month) per day HCPCS codes should be billed in situations where an ESRD beneficiary permanently changes their MCP physician during the month. For example, the new MCP physician has the ongoing responsibility for the evaluation and management of the patient's ESRD-related care and is not part of the same group practice or an employee of the first MCP physician. The new MCP physician should use the appropriate per diem HCPCS code when submitting claims for ESRD-related services for the remainder of the month, when the first MCP physician furnishes a complete assessment of the beneficiary during the month.

If the first MCP physician does not furnish a complete assessment of the patient during the month the patient permanently changes their MCP physician, the new MCP physician may bill for the appropriate MCP service based on the age of the patient and number of visits furnished and the first MCP physician may bill the appropriate per day HCPCS code as discussed above.

Example: An ESRD patient residing in Virginia Beach, Virginia for the first 20 days of the month, moves to Atlanta, Georgia. As a result, a different physician or practitioner is now responsible for the ongoing management of the beneficiary's ESRD-related care. Both the first and second MCP physician furnishes a visit with a complete assessment of the patient and establishes a monthly plan of care. In this situation, the first MCP physician should bill the MCP service that reflects the number of visits he or she furnished during the month and the second MCP physician should bill the age appropriate per day ESRD-related services code. Thereafter, the new MCP physician would bill for the MCP service.

In this example, if the first MCP physician does not provide a complete assessment of the patient, he or she should bill 20 units of the per day ESRD-related services code, but may not bill for the MCP during the month the beneficiary permanently changes his or her MCP physician. The second MCP physician may bill for the MCP service after furnishing a complete monthly assessment of the ESRD beneficiary that includes establishing the patient's plan of care and at least one face-to-face visit.

140.3 - Data Elements Required on Claim for Monthly Capitation Payment

(Rev.1456, Issued: 02-22-08, Effective: 03-24-08, Implementation: 03-24-08)

- A. Elements 1 through 13 of the Form CMS-1500 are completed in accordance with the regular instructions
- B. Elements 14 through 20 of the Form CMS-1500 are omitted.
- C. Element 21 must contain the name and address of the facility involved with the patient's maintenance care or training.
- D. Element 23A must show the diagnosis, and whether the patient is in training for self-dialysis. Element 23B is left blank.
- E. Element 24A must show the dates of service during the month that are included in the MCP. The period includes *the full calendar month the MCP physician or practitioner was responsible for the beneficiary's ESRD related care.*

For the first month the beneficiary begins dialysis treatments, the first date the dialysis treatments begin through the end of the calendar month should be used as the dates of service.

For outpatient ESRD-related services furnished for less than a full month, per day as discussed in 140.2 (e.g. transient patients, partial month due to hospitalization, transplant, or death), the first and last date the physician or practitioner was responsible for the beneficiary's ESRD-related care during the month should be used as the dates of service. Noncontinuous dates should be billed on separate claim lines, (e.g. 1/1/08 – 1/7/08 and 1/20/08 – 1/31/08). A separate monthly claim should be submitted when the duration of ESRD-related services, per day, overlaps two different months as discussed in 140.21 (e.g. August 15 – September 7).

- F. Element 24C must show the initials "MCP" as the indicator needed to identify the claim as a request for the MCP.
- G. The remainder of the Form CMS-1500 is completed in accordance with the general instructions.

140.4 - Controlling Claims Paid Under the Monthly Capitation Payment Method

(Rev.1456, Issued: 02-22-08, Effective: 03-24-08, Implementation: 03-24-08)

Contractors must be able to identify dialysis patient history records and physicians who furnish services related to dialysis.

In processing claims reimbursed under this method, *contractors* must assure that:

- Only one monthly payment is made for any renal disease patient per month;
- The MCP *payment is made* after the month has passed; i.e., do not pay the MCP in advance of the services actually furnished;
- *The payment amount is based on the age of the beneficiary and the number of visits furnished during a calendar month (center based patients);*
- Duplicate charges billed as a duplicate MCP or as separate charges for services covered by the monthly payment are denied;
- Where several physicians *or practitioners* form a team to provide the monthly continuity of services to a group of patients, make only one monthly payment for each patient.
- Concurrent services by another physician *or practitioner who is part of the MCP practice team* are covered and reimbursed *separately* only for services not included in the MCP (*e.g. a visit not related to managing the patients ESRD*); *and*
- If payment for inpatient hospital services is claimed in addition to the MCP, and assignment is taken only with respect to the MCP, follow the instructions in *Pub. 100-04, chapter 1, §30.3.12.3.*

Contractors must conduct periodic review of a randomly selected sample of patients' histories with reimbursement under the MCP method, to evaluate whether the number of and types of services billed separately from the MCP are appropriate considering the individual patient's medical condition.

Make separate payments for medically necessary services that are included or bundled into the MCP (e.g., test interpretations) when furnished by physicians other than the monthly capitation payment physician. According to the Renal Physicians Association, these test interpretations are billed separately only in rare circumstances.