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INTERIM POLICIES AND PROCEDURES CONCERNING CHRONIC RENAL DISEASE

Part A Intermediary Letter, July 01, 1973 No. 73-25;, Part B Intermediary Letter, No. 73-22; July 1973.

Chronic renal disease--Interim policies and procedures.--

Following are specific coverage requirements for renal transplants and dialysis, and procedures and policies for reimbursement of providers, limited-care facilities, and physicians. Included are bill-processing procedures and exhibits of Form SSA-2742, Explanation of the Medicare Chronic Renal Disease Patient History, and Form SSA-27-43, Medicare Chronic Renal Disease Charge and Service Information, and instructions for their completion.

Back references: ¶24,109, ¶24,109.15, ¶24,109.61.

Outline

Part A Intermediary Letter No. 73-25;

Part B Intermediary Letter No. 73-22

Processing and Payment of Claims for Renal Dialysis and Transplant Services Performed for Eligible Medicare Beneficiaries After June 30, 1973

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I. Introduction and Purpose

This Intermediary Letter contains interim instructions for the processing and payment of claims for renal dialysis and transplant services performed for eligible Medicare beneficiaries after June 30, 1973, under the provisions of Section 299I of P. L. 92-603 (see Part A I. L. 72-28, Part B I. L. 72-31 for a general summary of this provision.)

Under this provision of the law both hospital-based and limited-care facilities (provider or nonprovider operated)* must meet conditions prescribed by the Secretary in order to participate in the program. These conditions include the establishment of minimal utilization rates for participating facilities and a requirement for Medical Review Boards to screen the appropriateness of patients for the prescribed procedures.

Effective July 1, 1973 and during the interim period until such conditions have been approved by the Secretary and certification of facilities has been accomplished, intermediaries should accept billing from all participating providers as well as nonprovider limited care dialysis facilities meeting minimal conditions described in this letter, and in operation as of June 1, 1973. Exceptions may be granted to this general rule if justifications submitted for such exception are found appropriate. It should be emphasized that when conditions of participation are approved and the certification process is completed, it is contemplated that there may be restrictions on the number of approved dialysis and transplant facilities for a given area. Therefore, some of the facilities may no longer qualify for reimbursement at a subsequent time.

We are requesting all BHI regional offices to identify facilities providing renal treatment services and to obtain an expression of intent to participate. On an interim basis effective July 1, 1973, provider operated facilities expressing such an intent will be advised to bill their intermediary using their assigned Medicare Provider Number. Nonprovider Limited Care facilities expressing intent to participate will be assigned a temporary identification number in the 2500 to 2999 series. Nonprovider Limited Care facilities are being asked to identify the hospital with which they are affiliated or have an agreement for back-up care for their patients. These facilities will be required to submit bills for their services to the Part A intermediary servicing this hospital. Prior to July 1, 1973, these facilities billed services for Medicare patients to a Part B carrier.

The fact that virtually all renal dialysis and transplant services will be paid for under the recent legislation makes it necessary to modify policies that were appropriate when only the aged were involved. The legislative history recognizes, for example, that this greatly expanded coverage removes the constraints on costs and charges that have been exercised in the past by the non-Medicare population and that new reimbursement guidelines will be necessary.

Before the final reimbursement and coverage procedures can be developed and implemented, it will be necessary to complete intensive reviews of present patterns of organization and delivery of services in question, and reimbursement practices. This is a highly complex task. It will not be completed by July 1, 1973.

While additional study will be required prior to the issuance of policies and regulations that will provide the full safeguards intended by Congress with respect to this extension of Medicare coverage, the special interim coverage and reimbursement policies outlined in this letter will become effective July 1, 1973. As data are

received and analyzed, and reimbursement methodology is studied further, more detailed instructions will be developed and issued. Facilities and physicians should, therefore, be aware that the current payments are an interim measure for activating the program on the effective date and are subject to modifications as data obtained indicate revisions are appropriate. Modifications will follow aimed at reimbursement supporting the delivery of quality services in an efficient manner.

All renal treatment services billed for by treatment facilities will be submitted on the SSA-1453, "Inpatient Hospital and Extended Care Admission and Billing" form and the SSA-1483, "Provider Billing for Medical and Other Health Services Billing" form, plus special supplemental forms. Facility billings will be processed by Part A intermediaries. This is true even though the facility may be participating as a nonprovider limited care facility rather than a provider of services. The special supplemental forms and procedures for their use are in Part VII.

Facilities will be advised to bill on a monthly basis, i.e., beginning August 1, 1973, for services rendered in July. All bills submitted by beneficiaries or suppliers for home dialysis equipment and supplies will be submitted to Part B carriers on an SSA-1490, "Request for Medicare Payment" form. Bills for physician services to the renal patient will be submitted to Part B carriers on the SSA-1490, SSA-1554, or SSA-1556.

II. Coverage

A. Transplant

1. Hospital Services

a. Basic Coverage.--(1) Living Donor.--Hospital services in connection with the acquisition of a kidney from a living donor for transplant in an eligible beneficiary are considered as services for the treatment of the beneficiary and are covered as such. (See b. below regarding deductible and coinsurance provisions. Specific procedures for developing allowable costs for excised kidneys are included in section IIIA of this letter.)

If the hospital excising the kidney does not participate in the Medicare program, the hospital costs associated with the donor's care and acquisition of the kidney can be paid for by the program only where an equally suitable kidney is not available from a participating provider. The amount of the payment to be made to the non-participating hospital will be subject to the guidelines contained in section IIIA of the letter.

(2) Cadaver Kidney.--Costs incurred by the provider in connection with the acquisition of a cadaver kidney are similarly reimbursable on the donee's account to the hospital performing the transplant. The hospital performing the transplant will bill the program. Typical provider costs involved in excising the cadaver kidney include: surgeon's service, operating room, anesthetist, donor evaluation and support, preservation supplies (perfusion materials and equipment), preservation technician, telephone, consultation charge, intensive care costs, pathology, central exchange costs (transportation and packaging, administration costs, computer.) Thus, the services necessary to make the kidney available to the donee are covered in a manner analogous to coverage of a cardiac pacemaker.

Note: No program reimbursement may be made for the kidney itself, i.e., if a donor sells his kidney, the purchase price may not be reflected in any program payment.

Where a participating hospital other than the transplanting hospital excises a kidney, whether from a live or cadaveric donor, the requirements contained in section IIIA of this letter must be met by the donor hospital as well as by the transplanting hospital in determining the allowable cost of excision. Where a kidney is furnished to a transplant hospital by a participating hospital which performed the excision, the transplant hospital will pay the reasonable charge of the excising hospital.

The transplant hospital will then submit a bill in the amount of its reasonable charge for excision to its intermediary in the name of the donee.

Where it is determined that the kidney cannot be used after excision, the excising hospital will include the cost of excision in its costs as contained in section IIIA of this letter.

Where participating hospitals are members of a kidney procurement organization, administrative costs incurred by the organization should be spread ratably over all of the hospitals which subscribe to the service. As the

organizational entity is considered related to those hospitals which support its activities, the accumulated costs to be allocated to each hospital cannot exceed the actual allowable cost incurred in performing the organizational entity's administrative functions.

b. Deductible and Coinsurance.--Since services to the donor are considered for the benefit of the donee, deductible and coinsurance charges depend on the donee's status. The Part A deductible and coinsurance do not apply to the services to the donor.

c. Extent of coverage of services to donor.--There is not limitation on the number of days of care required by the donor directly in connection with the kidney transplant operation. Days of inpatient hospital care used by the donor should not be charged against either party's utilization record. However, the program's assumption of liability is limited to those donor expenses which are incurred directly in connection with the transplant. Expenses incurred for complications that may arise with respect to the donor are covered only if they are directly and immediately attributable to the surgery. Questionable cases should be submitted to SSA, BHI, Attn: DPMSA.

d. Part B coverage after donee has exhausted Part A.--If the donee has exhausted Part A benefits while the donor still requires and receives inpatient hospital care, including room and board, the program will pay for such care under Part B. However, the cost of these services will be provided for in the kidney excision standard charge reflected on the billing form submitted for the donee. Furthermore, there can be only one kidney excision standard charge to the program for each transplantation whether under Part A or Part B, depending on the donee's status on the day of implantation. The donee will be responsible for the amounts of any coinsurance which would have been applicable if he himself received the services. The donor's hospital costs are part of the costs of acquisition of the kidney and are covered as such, but these costs are reduced by the applicable Part B coinsurance. Of course, no payment may be made under Part B for services directly to the donee other than the usual medical and other health services. If the donee dies, donor expenses actually incurred after the death of the donee will be treated as incurred before the death of the donee. (More detailed instructions will be issued on this point.)

2. Physicians' Services

Expenses for physicians' services to the donor are treated as though they had been incurred by the donee. (See also II.A.1.a above.) For example, only one deductible per year must be met by the donee for services both to him and to the donor. If the donee dies, donor expenses actually incurred after the death of the donee will be treated as incurred before the death of the donee.

3. Other Services

a. Tissue Typing.--Tissue typing of the donee is, of course, a covered service. Tissue typing and tests necessary to determine the suitability of a living donor or a donated kidney are also covered as medical expenses necessary for the treatment of an eligible donee. The costs of these services are covered under the hospital insurance or medical insurance programs (see II.A.1.d., above). The cost of tissue typing will be reflected in the kidney excision costs. (See Part III.A.)

b. Preservation Laboratories.--The services performed by preservation laboratories are medically necessary for the treatment of a beneficiary's illness. A participating hospital will be reimbursed for the reasonable cost of such services which are performed by its own laboratory or which the hospital purchases from a free-standing preservation laboratory.

c. Transportation.--There is no provision in the law for payment of charges by an agent transporting a kidney for transplant in an eligible beneficiary if the agent bills the program or the patient directly. However, reimbursement may be made to hospitals under substantially the same conditions as those that apply to payment for services by preservation laboratories.

d. Registration Fees.--Reimbursement may be made to the participating hospital which expects to perform a kidney transplant for a patient, of the reasonable cost that it incurs in listing the patient and his blood characteristics with a professionally recognized organization that maintains a registry of potential transplant

candidates and which provides a regular listing of such patients to hospitals engaged in kidney procurement. See also Part III.A.2., Page 15, third paragraph.

B. Dialysis

1. Facility and Home

a. Both acute dialysis and maintenance dialysis for the stabilized patient with end-stage kidney disease are covered. Maintenance dialysis may be provided in a hospital outpatient department, in a limited care facility operated by a provider, or in a non-provider limited care facility; any of these may be a "self-care" unit. Equipment, supplies and services necessary for the facility to deliver the dialysis function are included in this coverage. As an interim measure and prior to the promulgation of regulations and certification of the facility, free-standing facilities must, as a condition of coverage: (1) meet State or local licensure requirements, if any; (2) be under the general supervision of a physician who need not be a full-time supervisor; (3) have an affiliation--e.g., have arrangements for back-up, etc.--with a participating hospital; and (4) agree that no charge will be made for a covered dialysis service provided by that facility that is in excess of the charge determined under the program to be the reasonable charge of that facility and agrees to bill the program and not the patient for amounts reimbursable under the program. ** Maintenance dialysis facilities first going into operation or substantially expanding their services after June 1, 1973 will need to meet these and other tests before being approved for participation. Regardless of dialysis setting, reimbursement is limited to three dialysis sessions per week for the chronic stabilized patient; however, additional treatments may be covered when determined to be medically necessary.

b. Medicare coverage of home dialysis is limited to coverage afforded by the durable medical equipment provision. (See section 25-1 of the appendix to Chapter II of the Part B Intermediary Manual.) It is believed that, where medically and psychologically appropriate, home dialysis is preferable to facility dialysis from the patient's standpoint and substantially less costly than out-of-home services. Consideration is therefore being given to the development of criteria for determining when home dialysis is indicated and for limiting reimbursement if facility services are provided instead. More detailed instructions on this procedure will be issued later.

c. Transportation to or from the dialysis facility is not ordinarily a covered service (see §6108 of the Part B Intermediary Manual).

2. Physicians' Services

a. General.--Payment for physicians' services is subject to the guidelines in §6102 of the Part B Intermediary Manual. The types of physicians' services rendered to chronic renal disease patients include: (a) inpatient services--for stabilization of renal failure and during hospitalization for a secondary condition, (b) necessary services performed during dialysis, and (c) follow-up office visits to review patient progress. Basically, physician services rendered a chronic renal disease patient are covered if determined to be reasonable and necessary.

b. Physicians' Services to an Inpatient.--Where a chronic renal disease patient is hospitalized for treatment of some other condition, it is often necessary for the attending physician to consult with a nephrologist on possible renal complications and to monitor the patient's progress. The carrier should, however, ascertain whether or when the concurrent services are duplicate.

c. Services During the Performance of Dialysis.--(1)--The performance of maintenance dialysis is generally not considered to require a physician's personal service to a patient. However, complications can occur which may require a physician's personal service.

Only a very small percentage--on the order of 5 percent--of dialysis patients require physician personal services during dialysis on a routine basis. When bills are submitted for such physician personal services, the carrier should require medical documentation of their necessity. Bills for physician personal services in connection with maintenance dialysis should not be allowed without clear evidence of medical necessity.

(2).--Interim conditions of coverage require that every dialysis facility must be under the general supervision of a physician. However, such services are not considered to constitute a patient-care service, and reasonable-charge

reimbursement will not be made for such services. Unit supervision is considered a facility service and should be included as a component of the cost or charge for the dialysis.

d. Follow-up Office Visits.--Chronic renal disease patients require regular periodic evaluation and laboratory tests. When physician services do not exceed the following interim guidelines, the services may be reimbursed without requiring medical documentation: (a) office visits for followup of stabilized patient--one per month; (b) in-depth evaluation of progress for stabilized patients--twice annually. When these guidelines are exceeded, payment should be made on the basis of medical documentation that establishes an abnormality requiring the added services.

e. Physician Service During Self-Dialysis Training.--Training of patients for self-dialysis requires a larger personnel input than ordinary chronic dialysis. The staff utilized in self-dialysis training also requires greater physician supervision; additionally, there is some patient care by a physician that is needed. The necessary physician supervision which is covered should be treated as a facility cost--similar to general supervision of a dialysis unit--and not as patient service.

3. Other Services

a. Self-Dialysis Training.--Payment for self-dialysis training carried out in connection with dialysis treatments may be made when the training expense is included in the cost of the dialysis treatment; there is no provision in the law for recognizing a separate charge for training. In addition, in determining average dialysis cost, training expense should be attributed only to training dialyses, i.e., the additional cost attributable to training expense should also be reflected in the standard schedule of charges.

b. Home Dialysis Supplies.--In general, Medicare coverage of supplies utilized in conjunction with durable medical equipment covers those items necessary for the effective use of the equipment. Coverage of supplies and equipment utilized during dialysis are subject to the rules set out in the following: (a) §6107.4 and §6107.5 of the Part B Intermediary Manual; and (b) §3113.3 and §3113.4 of the Part A Intermediary Manual. However, the home patient is limited to a maximum of 3 dialyzers per week, e.g., coils, hollow fiber dialyzers, etc.

Heparin, although normally a prescription drug, is classified as a supply when used as a dec clotting element of the dialysis process and is covered as such. Supplies and equipment, other than the durable medical equipment itself, purchased at the initial installation date are also covered; however, physician instruments and nonmedical supplies are not covered unless included in a package charge for the dialysis equipment, i.e., they need not be carved out of the initial purchase package price and the total need not be reduced. (See sections: (a) 25-5 of the appendix to Chapter II of the Part B Intermediary Manual, and (b) 60-1 of the appendix to Chapter II of the Part A Intermediary Manual.) Thus, some of the items which are paid for if included in the initial package of equipment are not covered when purchased individually, e.g., when replaced on an item-by-item basis.

c. Home Dialysis Aides.--One of the purposes of home dialysis is to lower the cost of dialysis by replacing expensive institutional labor with an unpaid companion or spouse. The program will not cover the cost of an aide whose sole purpose is to aid a patient in the performance of home dialysis. When the home dialysis partner is unable to assist with dialysis, the normal practice is for the patient to be dialyzed in a center which is backing up and overseeing his home care. If no center is accessible to the patient and in effect the home is converted into a limited care facility with the attendance of a dialysis aide during dialysis, the case should not be paid, but referred to SSA, BHI, attn: DPMS, for a determination of **whether** an exception might be made to permit payment for the aide's services. In addition, home health benefits rarely apply since dialysis patients are rarely homebound. Instances where it appears home health benefits apply should be referred to the SSA, BHI Attn: DPMS.

d. Training Family Member or Other Home Aide.--Costs incurred by a provider or free-standing facility in training the unpaid home aide are includable in the costs of the training dialysis sessions. Training dialysis sessions are limited to three times per week unless justification exists for more frequent training dialyses. Transportation to the

training facility, lost wages of the attendant and the cost of lodging during training are not covered items of home training.

e. Laboratory Tests.--Laboratory tests are essential to monitor the progress of chronic renal disease patients. The following list and frequencies of tests constitutes the level and types of routine laboratory tests that are to be covered. Additional types of tests or tests at greater frequencies must include reasons for the test's medical necessity. The routinely covered regimen is as follows:

Per Dialysis

Hematocrit

Per Week

Prothrombin time for patients on anti-coagulant therapy

Serum Creatinine

BUN

Monthly

CBC

Serum Calcium

Serum Potassium

Serum Chloride

Serum Bicarbonate

Serum Phosphorous

Total Protein

Serum Albumin

Alkaline Phosphatase

SGOT

LDH

Guidelines for tests other than those routinely performed include:

Bone Survey - annually

Nerve conductor velocity test (peroneal NCV) - once every 3 months

EKG - once every 3 months

Hepatitis associated antigen tests - once every 3 months

These and all other nonroutine tests must be identified separately on the Form SSA-2743 (see VII, B.4.b.).

Laboratory tests are subject to the normal coverage requirements in §6104 ff. of the Part B Intermediary Manual. If the laboratory services are performed by a free-standing facility, it must meet the conditions of coverage for independent laboratories.

f. Part B Coverage of Blood Furnished to Individuals In Dialysis.--Blood is covered under Part B under the incident-to provision. Where it is provided in a hospital outpatient department, physician supervision can ordinarily be presumed. Where it is covered outside the hospital premises, whether in a hospital satellite or in a free-standing nonprovider facility, it must be provided under the direct personal supervision of a physician. (See Sections 3112.4 and 6103 of the Part A and Part B Intermediary Manuals.) Where it is furnished in a provider, the blood should therefore be billed for as a separate line item from the dialysis charge and subject to the usual Part B requirements; where it is furnished in a nonprovider facility, billing for the blood is to the carrier and should show the name of a supervising physician.

III. Reimbursement of Provider Facilities

A. Specific Requirements to be Observed by Providers Performing Kidney Transplantations and/or Furnishing Kidneys for Transplantations

1. Cost Treatment of Kidney Transplantation.--Where the provider performs kidney transplants, the costs associated with the transplant itself, exclusive of any costs applicable to the acquisition of the kidney, will be treated as any other surgical procedure subject to the specific requirements contained elsewhere in this letter. In other words, it is not necessary to separately account for these costs for cost reporting purposes.

2. Cost Treatment for Acquisition of Kidneys.--Providers must separately identify and apportion to the Medicare program the costs applicable to the acquisition of kidneys used for transplantation. This rule applies whether the acquisition is from a living donor or a cadaver and whether the kidney is obtained from another provider or is excised by the provider. In order to accomplish this and to meet the program's cost reporting requirements, the following rules apply:

Providers must separately accumulate their routine patient day statistics and ancillary charges related to kidney excisions. The ancillary charges would reflect the usage of the various ancillary service cost centers, such as operating room, anesthesiology, etc., which are needed in kidney excisions. After the cost-finding process, the providers must apply the appropriate apportionment methodologies (using days of service and charges) to its routine and ancillary service cost centers to determine the aggregate costs of kidney excisions. These apportionment computations must be made for all in-house excised kidneys, regardless of whether they are from live donors or cadavers and regardless of whether the excised kidneys are transplanted by the provider, furnished to other providers for transplantation, or are diseased or for other reasons are not ultimately transplanted. Where a provider which performs kidney transplantations also acquires kidneys from other providers, the amounts paid to other providers for the acquired kidneys must be added to the cost of all in-house excised kidneys. A separate cost reporting schedule will be provided for these computations.

Under either the Departmental or Combination Method of Apportionment, the cost of kidney acquisition thus determined will be apportioned to the Medicare program based on the ratio of program charges to total charges. Providers must establish a standard charge reasonably related to cost for live donor kidneys and a standard charge for other kidneys and record the appropriate charge for each kidney transplanted by the provider, for each kidney sold to other providers performing transplantations, and for each kidney used or sold for reasons other than transplantations. A charge will not be recorded for a kidney which is diseased or for other reasons is not usable; in this manner Medicare will reimburse for its proportionate share of the cost of such unused kidneys. For purposes of the apportionment computation, program charges will consist of only those charges applicable to beneficiaries on whom the provider performed a transplantation. All other charges, including those billed to other providers for transplantation, will be considered nonprogram charges.

Where a provider performs a transplantation and must purchase the kidney from another provider, the transaction must utilize the "under arrangements" concept. That is, the provider excising the kidney cannot bill the program directly, but must receive payment from the provider performing the transplantation.

When a participating provider sells kidneys to other providers, it will use its standard charge to bill the other providers. If the total revenue received for kidneys furnished to other providers during the cost reporting period exceeds the related excision cost, such excess will be subtracted from Medicare reimbursement otherwise due the provider. This adjustment is necessary to prevent program payment in excess of cost where a participating provider furnishes a kidney through another participating provider at charges in excess of cost.

In this connection it should be noted that virtually all kidney transplants will be covered by the program and, thus, covered by the participating provider's agreement to furnish covered services on a cost basis.

A kidney may be purchased from a facility not participating in the Medicare program only where an equally suitable kidney is not available from a participating provider. In such circumstances, the charge (if reasonable) by the nonparticipating donor facility is allowable for inclusion with the donee hospital's total excision costs.

Many providers utilize the services of kidney procurement organizations which service member providers in the location, acquisition, and sale of kidneys for transplantation. The costs of such procurement organizations which are applicable to the member hospitals for kidney services may be allocated to the member hospitals on a logical basis. The basis used must represent sound accounting practice and represent the cost of services rendered to each provider. With respect to the member providers, the costs which are allocated from the procurement organization should be added to the other kidney excision costs.

Each provider billing the program for a kidney transplantation must show its standard charge for kidney excision cost on a separate line on the billing form. Detailed billing instructions are furnished elsewhere in this letter.

For cost reporting periods which begin before July 1, 1973, and end after June 30, 1973, it will not be necessary for providers to reconstruct or estimate the cost prior to July 1, which would be applicable to kidney excisions. These cost reporting and billing instructions will be implemented as of July 1, 1973. In other words, providers may continue their current billing and costing procedures through June 30, 1973.

B. Specific Requirements to be Observed by Providers Furnishing Renal Dialysis Services.--

1. Establishment of Separate Cost Centers.--The capture and identification of costs related to renal dialysis treatments is necessary in controlling costs and for program evaluation purposes. In order to meet these requirements, those facilities which furnish dialysis services as of July 1, 1973, will be required to account for such costs by establishing a separate ancillary service cost center for renal dialysis services whether the facility uses the combination or departmental method of apportioning costs. Under both methods the expenses of the general service departments will be distributed on the usual bases to the renal dialysis center as well as to the other ancillary, inpatient and outpatient centers. Under the combination method of apportionment, the renal dialysis cost center will be separately apportioned on the basis of the ratio of program charges to total charges, similar to the apportionment under the departmental method.

In accumulating costs and charges applicable to this center, no other ancillary services will normally be included even though routinely administered during the course of the dialysis treatment. However, if a provider physically performs a few minor routine laboratory services associated with dialysis in the renal dialysis department, such costs should remain in the department for cost finding and apportionment purposes. Similarly, the provider's standard schedule of charges for the renal dialysis department must also reflect these minor routine laboratory services either as part of the dialysis charge if not charged separately, or on an itemized basis if charged separately.

In the vast majority of situations, though, the laboratory services routinely administered during the course of dialysis treatments will actually be performed in the provider's laboratory. Under such circumstances, the cost and charges related to the laboratory services performed in connection with renal dialysis will remain in the laboratory cost center and the costs involved will be apportioned along with other laboratory costs under the general rules applicable.

Furthermore, with respect to physicians' services, for each routine dialysis performed there will be recognized only a facility component of service; consequently, the cost of the administrative and supervisory role of the physician in the facility would be recognized only as part of the facility overhead, and included in the renal dialysis cost center. Where a separate identifiable professional service is rendered, when needed for periodic appraisals of the patient's condition or because of a special abnormality, billing for such services will follow the procedures outlined elsewhere in this letter.

2. Special Exception for Determining Allowable Dialysis Costs by Providers Who Have Not Accumulated Such Costs In a Separate Cost Center Prior to July 1, 1973.--Where the provider's accounting period ends before June 30, 1974, and it has not prior to July 1, 1973, segregated the costs associated with performing dialysis services, but included such costs in another department, e.g., laboratory, the provider may determine the costs of dialysis for the period prior to July 1, 1973, by applying to the combined departmental costs as of June 30, 1973, the ratio of direct dialysis costs after June 30, 1973, to the combined direct costs of the department and the new dialysis department with which it was previously combined. The total direct dialysis costs so determined

are then includable in the dialysis cost center to be considered in the allocation of administrative costs in the normal step-down procedures. The determination of charges for the period prior to July 1, 1973, would follow basically the same procedures.

Example for Determining Allowable Dialysis Costs

Accounting period - January 1, 1973 - December 31, 1973

1. Total direct laboratory costs (including dialysis)	
for the period 1/1/73-6/30/73	\$100,000
2. Total direct laboratory costs less dialysis costs	
for the period 7/1/73-12/31/73	148,500
3. Total direct renal dialysis costs for the period	
7/1/73-12/31/73	1,500
4. Total combined direct laboratory costs for the	
period 7/1/73-12/31/73 (line 2 + line 3)	150,000
5. Ratio - line 3 divided by line 4	1%
6. Apply ratio to period 1/1/73-6/30/73 (line 5 x	
line 1)	1,000
7. Total direct costs to dialysis center for the	
accounting period (line 3 + line 6)	\$2,500

Example for Determining Allowable Dialysis Charges

Accounting period - January 1, 1973 - December 31, 1973

1. Total laboratory charges (including dialysis)	\$110,000
for the period 1/1/73-6/30/73	
2. Total laboratory charges less dialysis charges	158,400
for the period 7/1/73-12/31/73	
3. Renal dialysis charges for the period 7/1/73-	
12/31/73	

Inpatient - \$400	1,600
Outpatient - 1,200	
4. Total combined laboratory charges for the period 7/1/73-12/31/73 (line 2 + line 3)	160,000
5. Ratio - line 3 divided by line 4	1%
6. Apply ratio to period 1/1/73-6/30/73 (line 5 x line 1)	1,100
7. Total charges for apportioning costs (line 3 + line 6)	2,700

8. Charges used to apportion costs for the accounting period:

[Illustration not reproduced.]

Where the provider has properly segregated the costs and charges of renal dialysis services for the entire accounting period wherein part of the period includes services provided prior to July 1, 1973, the provider is expected to follow its normal cost-finding procedures in determining the costs of the dialysis center and apportion these costs on the basis of the actual accumulated dialysis charges.

C. Special Instructions to Intermediaries for Monitoring The Reimbursable Amount Per Dialysis.--As previously indicated, permanent program rules will provide specific limitations on the reimbursable cost of dialysis. Until such specific limitations are established, the intermediary will be expected to monitor dialysis charges and costs and to verify the reasonableness of the amount to be reimbursed for renal dialysis services where the average cost of routine maintenance dialysis treatment is equal to or less than the overall limits described below and the facility exceeds the particular rate established for its, as described below.

Where average costs (or charges) exceed the overall limits, the case will be referred to Central Office as described below. Unless an exception is made as described below, reimbursement for maintenance dialysis services will be limited to \$150 per treatment and \$190 per training self-dialysis session; \$145 and \$185, respectively, when laboratory is billed separately, under appropriate circumstances.

These amounts include the provider (or facility) component of physicians' services as well as routine laboratory services whether or not performed in the dialysis department. (See listing of routine laboratory services in Part II,B.3.e. above.) If the routine laboratory services are performed by an independent laboratory and billed separately to the Part B carrier, the intermediary will verify for reasonableness, the average cost per routine maintenance dialysis treatment in excess of \$145 per treatment--or \$185 per training self-dialysis session.

Where the reimbursable amount claimed is in excess of these dollar figures (or of the particular rate established for the provider or facility) or otherwise is found unreasonable, the provider or facility should be so notified and given an opportunity to offer further evidence justifying the reimbursement. Amounts above the dollar figures cited above (or of the particular rate established for the provider or facility) are not be considered reasonable costs (or reasonable charges see Part IV, following) unless there is a finding that they are justified. Until further notice, this finding will be made in Central Office where the overall limits (\$150, \$190; \$145, \$185) are exceeded. (See the routing instructions below.) The intermediary should in the meantime make reimbursement in such

cases, within the limits described above, if justified. When the intermediary is advised of the decision as to whether an amount in excess of these limits is justified, the provider (or facility) should then be informed by the intermediary of the maximum to be applied and the date it will become applicable and the new accepted established rate.

During the interim period beginning July 1, 1973, and continuing until permanent rules are established, intermediaries should exercise close surveillance of charges for renal dialysis and kidney transplants billed to the program. Specifically, intermediaries should obtain the renal dialysis and kidney transplant charges in effect at the time the current interim rates were established and monitor billed charges to preclude the possibility of revision of charges being made without notification and, where appropriate, adjustment of interim rates. Further, the intermediary should disallow coinsurance amounts based on charges in excess of the charges imposed by the provider as of the date of this letter except where the increase in charges has been approved. The intermediary will be notified shortly of the criteria for approval and the process to be employed. Unapproved increases in charges are to be deemed by intermediaries to be unreasonable on the grounds that the increases exceed the amounts customarily charged within the meaning of Section 1866 (a) (2) (A) (ii) of the Social Security Act.

In order to provide the intermediary with the necessary cost data to assist the intermediary in making an evaluation of the amount of reimbursement per dialysis, each intermediary will be supplied with a detailed questionnaire along with a letter of explanation for distribution to each provider and facility that furnishes such services. Each provider and facility will be required to furnish the statistics, cost data, and other relevant information called for by the questionnaire and submit the completed questionnaire to the intermediary within 30 days after receipt.

Where the dialysis amount claimed is in excess of the amounts previously specified, or otherwise appears unreasonable, the specific reasons why the provider or facility considers such an amount justifiable must be documented and attached to the questionnaire. *** After each questionnaire, whether or not such an issue is involved, has been processed by the intermediary, it is to be forwarded to the following address:

Bureau of Health Insurance
Division of Provider Reimbursement and
Accounting Policy, Program Policy
Attn: Cost Analysis Branch
P.O. Box 133
Baltimore, Maryland 21235

As soon as possible, intermediaries will be sent a supply of questionnaires with instructions to be issued to providers and facilities that furnish dialysis services. Also included will be a letter for each provider and facility that will explain the reason for the questionnaire, contemplated regulatory requirements concerning various limitations expected to be imposed and other information. The letter and form should be made immediately available to each provider and facility performing renal dialysis services.

Time limitations have precluded consultation with intermediaries regarding the policies contained in this letter; however, any questions may be directed to the Bureau of Health Insurance for resolution.

IV. Reimbursement for Non-Provider Services

A. Out-of-Hospital Dialysis Centers

The reimbursement of a non-provider facility will be through the intermediary servicing the provider with whom the facility is affiliated under the renal disease program. For purposes of monitoring the reimbursement per dialysis in the non-provider facility, the screening guidelines and approval process set forth in Section III.C. (Reimbursement of Provider Facilities) should be followed. (The charges for dialysis treatment when a patient is being trained to perform the procedure himself at home will be higher than those for chronic maintenance

treatments. This is because the training process requires closer medical and other types of supervision. Consequently, the costs for training the patient will exceed the costs incurred by the dialysis center in delivering the service to a stable patient on maintenance dialysis.)

For the period beginning July 1, the estimated customary charge will be derived from the reimbursements from all parties made to the dialysis center for the services rendered to the patients during the prior 12 months. It is quite possible that several levels of payments were made, depending on the allowable limits under the third-party payer's programs, i.e., State kidney disease programs, Blue Shield and other health insurance plans, Medicare, etc. The weighted average of all such reimbursements should be used to calculate the estimated customary charge. In addition, the rules for applying prevailing charge and comparability limitations should be implemented. No increase in these customary charges will normally be allowed until further instructions are issued. However, if a dialysis center can demonstrate unusual hardship flowing from application of the customary charge rule, the center may submit documentation and special arrangements may be made for an equity adjustment, as long as payment does not exceed the prevailing charge and does not violate the Economic Stabilization Program rules. Where a limited care facility receives services for its patients from a renal disease treatment organization or facility, the limited care facility should be encouraged to purchase such services and incorporate the expenses in its costs or charges. See also Part IV.B.3. below.

B. Laboratory Tests

Covered laboratory tests, routine and non-routine, performed for the dialysis patient will be billed to the intermediary on the SSA-1483 billing form when they are performed or arranged for by the dialysis treatment facility. Where such services are performed outside the facility by a non-provider and not under arrangements, the tests will be billed to the Part B carrier, e.g., an independent laboratory or the attending physician performs the test.

However, routine laboratory services described in Part II, B. (3) (e), will ordinarily be totaled with dialysis services in determining whether the pertinent screen is exceeded.

1. Diagnostic tests performed by an independent laboratory for which payment is made to the laboratory pursuant to a contract between the Secretary and the laboratory, shall be paid in amounts equal to 100 percent of the negotiated rate for such tests. No deductible will be applied in such instances.
2. Where the laboratory testing is performed by an attending or consulting physician or by an independent laboratory where no such contract as in (1) above exists, the carrier shall apply the customary and prevailing criteria for determining the reasonable charge of such tests including customary charge profiles of those physicians.
3. With respect to X-rays or EKG's (or the physician service component thereof) performed in the dialysis center, the carrier shall use the same coverage and reasonable charge criteria it uses for determining the coverage and reimbursable amounts for such services when performed in a physician-directed clinic. See for example, §§6103 and 6104 of the Part B Intermediary Manual. Where the supervising physician and the auxiliary personnel are both employees of the physician-directed facility, the employer-employee relationship requirement is considered met.

C. Reimbursement for Home Dialysis

On July 1, 1973, patients who are receiving home dialysis treatments will continue to be reimbursed under the reasonable charge criteria for durable medical equipment. (See sections 6107 or 6750 of the Part B Intermediary Manual.) Contractual arrangements entered into by the patient for the leasing or purchase of a dialysis machine and the delivery of disposable supplies will generally be accepted under presently applicable criteria. Carriers should ascertain whether the suppliers, who made these contracts, can make arrangements to have all supplies furnished through the designated facility in the locality that is to provide support services to home dialysis patients, as this is considered more desirable. If the suppliers and the designated facility agree to have the supplies routed through the facility, the reimbursement of the necessary supplies will be made by the intermediary servicing the facility--on a reasonable-cost basis. The facility may include in its billings as a

component of the charge for the supplies, the cost of its other services to these patients, including telephone availability, equipment maintenance, advice on diet, etc.

Patients entering into a home training program after June 30, 1973, and beginning home dialysis treatments, are expected to ordinarily have all their supplies furnished to them by the facility designated to provide their support services--with reimbursement on a reasonable cost basis. Patients, who wish to purchase home dialysis equipment directly where facility services are alternately available, should be informed that hospitals and other facilities providing support services to home dialysis patients may be able to purchase or lease such equipment at prices lower than those available to individual buyers. For this reason, it would be advisable for the individual patient to determine whether such an arrangement is available to him so he can avoid a higher coinsurance obligation incurred through his own purchase or lease of the equipment. Furthermore, if a higher amount is paid than would be required if facility equipment and supply services were used, this charge may be found unreasonable and only a lesser figure may then be reimbursable under the program.

V. Reimbursement for Physicians' Services In Connection With Dialysis Patients

A. Out-of-Hospital Dialysis Center

Fee-for-service reimbursement for physicians' services in an out-of-hospital (as well as hospital) dialysis center shall be made only when an identifiable service to the patient is performed, e.g., the patient goes into shock, experiences severe chest pains, etc. Supervision by a physician of the dialysis "run" is part of the facility cost for the dialysis and is not reimbursable as a separate charge. See also Part III. B.1., last paragraph.

1. Allocation of Cost of Supervision

a. When a dialysis charge includes a charge for a physician's supervision during the treatment, the intermediary should determine what proportion of the charge can be allocated to the procedure as a cost. If the physician is a salaried employee of the dialysis center, that proportion of his salary which is for non-patient care, i.e., administrative activities, supervision, training, etc., can be allocated to the facility's overhead. If the physician receives another form of compensation, which is included in the dialysis charge regardless of whether a physician service is rendered, the intermediary should determine what percent of his compensation reflects the routine dialysis supervisory services. This percentage can be annualized into dollar amounts and then allocated into a cost per dialysis.

b. Where a separate charge is billed by a physician to the carrier for supervisory services, whether he is an employee of the facility or a private practitioner, the charge should be disallowed as not reflecting "physicians' services" with instructions that such services may be reimbursed as part of the dialysis service when included in the facility charge for dialysis.

2. Physicians' Patient Care Services

Where a physician's personal service is needed in a dialysis center because of an adverse reaction in the patient's condition, the reasonable charge for the physician's service will be as follows:

a. If the service is of an emergency nature, the carrier should apply the customary and prevailing charge screens it has established for emergency room services by physicians.

b. If the service is not of an emergency nature, the carrier should apply the customary and prevailing charge screens it has developed for "Office Visits - Extended Examinations, Evaluation, or Treatment." (See 1969 CRVS.)

c. Dec clotting of an A-V shunt is normally performed by the patient himself when he is on home dialysis treatments. The patients in a dialysis center may be unable to perform this technique for medical or other reasons. Therefore, when a physician in a dialysis center declots an A-V shunt, the carrier may allow payments for this service in amounts up to \$25. The carrier should, however, maintain a utilization screen on the frequency of such services to patients in dialysis centers.

When the above services are performed by a physician who is receiving a salary or other compensation from the dialysis center and for whom the carrier has no customary charge profile, the reasonable charge for his service

will be the actual charge, the prevailing charge in the locality for the service, or in the case of Item c., \$25.00, whichever is the lowest.

B. Other Physicians' Services.--

For the physician services received in the physician's office or other sites the reasonable charge criteria now in effect will be applied with certain exceptions. In other words, if the patient is treated at home, the reasonable charge screens for Home Visits will be applied, etc. (See Section II.B.2. (d) for exceptions which apply to routine monitoring office visits for reassessment of the patient's condition.)

VI. Reimbursement to Physicians for Physician's Service In Renal Transplantation

Until sufficient charge and cost data on renal transplantation are accumulated to support a modification, reimbursement guidelines which should be applied in connection with the surgical fees for this procedure will be set out in a confidential I.L. supplement.

VII. Intermediary and Carrier Query and Bill Processing Procedures

A. General.--Because Section 2991 of the 1972 Amendments together with other provisions of law, provides national insurance protection to almost all persons with end-stage renal disease, SSA will conduct an ongoing study beginning July 1, 1973, to evaluate costs and utilization of services in connection with this disease. Special bill processing procedures will be added onto the usual bill processing methods currently followed by intermediaries and carriers to facilitate fast feedback to SSA of data not obtainable through the regular claims processing system.

All patients with chronic renal disease (CRD) entitled to Medicare benefits will be included in the study, i.e., Section 2991 beneficiaries, persons over 65 years of age and disability insurance beneficiaries covered under other provisions of the Medicare law. These special bill processing procedures apply to all CRD beneficiary bills whether the services rendered were for renal, non-renal, or a combination of renal and non-renal treatment.

There are two available treatments which may preserve life in the case of end-stage renal disease: transplantation of a kidney from a live donor or a cadaver and continuing dialysis.

The transplantation of a kidney is an inpatient service and, therefore, with the exception of physician services during the inpatient stay and during post operative outpatient treatment, all claims for transplant services will be processed by Part A intermediaries.

Dialysis treatment for chronic renal disease patients is provided in four basic alternate settings: a hospital based facility, provider limited care facility, non-provider limited care facility, and the patient's own home. There are varying levels of care in the different settings. Initially, if the patient is seriously ill, he may be dialyzed while an inpatient of a hospital; however, after stabilization, he is normally treated on an outpatient ambulatory basis. In any of the limited care facilities, he may receive extensive attention and professionals may perform all services needed to dialyze him or he may receive "self" care where he is expected to perform most services needed to dialyze himself with only minor assistance from technical personnel at the facility. In any of the settings, the patient may be trained to dialyze himself in his own home.

Most of the workload resulting from the CRD provision will be processed by the intermediary. Bills for dialysis treatment furnished by a hospital or by one of the limited care facilities (LCF) will be filed with the intermediary, even though prior to July 1, 1973, non-provider LCF's filed SSA-1490's with the carrier (see Part VII,B.2. for a full explanation of this change). Where a hospital or any type of LCF furnishes durable medical equipment and disposable medical supplies to the beneficiary, the facility will bill the intermediary for Medicare reimbursement. If the home dialysis patient has made an independent arrangement with a supplier for such equipment and supplies, the beneficiary or supplier will bill the carrier. The carrier will continue to handle bills received from physicians and independent laboratories.

All CRD beneficiaries will be identified on SSA's Health Insurance Master Record and the intermediary or carrier will have positive identification through the query process of such beneficiaries, to whom these special bill processing procedures apply.

An individual eligible under Section 299I must file an application with SSA to establish his entitlement to Medicare benefits. When the applicant's entitlement to 299I benefits has been established, the Health Insurance Master Record will identify him as a Section 299I beneficiary. The over 65 beneficiary and the disability insurance beneficiary will be identified from information received from renal treatment facilities and listings from the National Institutes of Health. A patient history form that will be submitted by a renal treatment facility with the first inpatient admission notice or SSA-1483 bill will also be used by SSA to place an indicator code in the HI Master Record. However, because some indicator codes will not be identified on the HI Master Record until 2-3 months after the effective date of July 1, 1973, special procedures will be applicable as explained in the Query Sections B.3. and C.1. listed below.

Because of the complex bill processing procedures applicable to CRD Medicare claims, it is suggested that intermediaries and carriers assign a special person(s) to handle all CRD beneficiary bills.

B. Special CRD Bill Processing Procedures Applicable to Intermediaries.--The two types of facilities submitting CRD Medicare claims to intermediaries are hospitals and limited care facilities (LCF). A provider limited care facility will follow procedures listed for outpatient hospital instructions. The non-provider limited care facility will follow instructions listed for Limited Care Facilities.

1. Hospitals.--Hospitals will provide inpatient and outpatient services to CRD beneficiaries. The SSA-1453 bill for inpatient services and the SSA-1483 bill for outpatient services will be submitted by the hospital. One monthly SSA-1483 bill should be submitted by the hospital for maintenance dialysis services to reduce administrative costs. In addition, to obtain the information needed to enable intermediaries to perform the type of claims review desired in processing CRD bills and to aid SSA in its study of this disease category, two additional forms will be obtained from the hospital.

One form, SSA-2742, Medicare Renal Disease Patient History, will be submitted by the hospital providing the patient's renal treatment, on a one-time basis when it submits the first inpatient admission notice or first outpatient bill, whichever occurs first. The hospital should keep a copy of the SSA-2742 for its own information and to aid the hospital in avoiding the submittal of duplicate SSA-2742's.

The SSA-2742 will be the basic CRD beneficiary file documentation for the use of the intermediaries in reviewing renal bills. It will also serve as a basic tool for gathering renal disease patient statistics. The SSA-2742 will furnish information about the patient's medical history and his current condition at the time the form is submitted.

The second form, SSA-2743, Medicare Chronic Renal Disease Charge and Service Information, is a supplement to each Medicare SSA-1453 or SSA-1483 bill submitted by the hospital providing the patient's renal treatment. It will provide detailed information for each type of renal treatment service furnished to a CRD beneficiary plus identification of charges for each type of service. Regardless of whether the services were for renal or non-renal treatment, an SSA-2743 must be submitted by the renal treatment hospital for each bill submitted. However, only limited information is required on the form if the treatment is non-renal.

Both SSA-2742 and SSA-2743 forms are fully explained in Section B.4. below.

2. Limited Care Facilities.--Prior to July 1, 1973, such facilities submitting Medicare bills filed SSA-1490's with carriers. Effective July 1, 1973, LCF's will be required to submit an SSA-1483, Provider Billing for Medical and Other Health Services, to the intermediary which services the hospital that the LCF is affiliated with.

Initially all LCF's furnishing services to a CRD Medicare beneficiary will be permitted to file Medicare bills with intermediaries if the LCF meets certain basic requirements. LCF's meeting the minimum requirements will be assigned temporary provider numbers by the BHI RO on or after the July 1, 1973 effective date of the amendment provision. Assignment of temporary provider numbers will permit the LCF to submit bills and to receive program payment for services rendered Medicare patients until SSA makes a decision as to whether the LCF may continue to participate in the Medicare program. An explanation of the transitional requirements for participating in the program is contained in Part II.B.1. of this IL.

Intermediaries should furnish SSA-1483's to LCF's before July 1, 1973. Since in some cases the patient may not yet have enrolled under Section 299I, the facility should obtain a signed SSA-1483 from the patient to protect

his entitlement rights. However, the intermediary should advise the LCF to hold all such bills until it has been notified of its temporary provider number by the HIRO. Once the facility has been assigned a provider number, the intermediary will provide the facility with SSA instructions for billing, supply the facility with additional billing forms and the two related billing forms, SSA-2742 and SSA-2743. The intermediary will then instruct the facility how to bill and will start to accept bills from the facility.

LCF's will be required to submit the two additional claims forms, SSA-2742 and SSA-2743, under the same circumstances and in the same manner as listed above for hospitals in addition to the SSA-1483 bill.

To keep administrative costs at a minimum, LCF's will submit only one monthly SSA-1483 for each CRD Medicare patient.

3. Intermediary Query Procedures.--It is anticipated that there will be about 10,000 CRD patients potentially eligible to Medicare benefits as of July 1, 1973. About 70% of these potential beneficiaries will qualify under Section 299I, but all may not have fully established their entitlement to Medicare benefits, i.e., these beneficiaries will not have received their Medicare HI cards and their Medicare entitlement may not be contained in SSA's HI Master Record as of July 1, 1973. The remaining CRD beneficiaries will be entitled to Medicare benefits under other provisions of the law and these beneficiaries will have received their Medicare HI cards and their Medicare entitlement will be contained in SSA's HI Master Record as of July 1, 1973. However, even in these cases the HI Master Record may not contain an indicator code to establish their CRD benefit status as of July 1, 1973. Therefore, where a renal treatment facility identifies a patient as having chronic renal disease, all bills should be held until a query response is received which has an indicator code identifying the patient as a CRD beneficiary. Where the patient is identified as a CRD beneficiary, query replies will include an S trailer with the following codes:

2 Individual covered under the CRD provision (Section 299I) of P.L. 92-603.

3 Individual covered by disability provision (Section 201) of P.L. 92-603, also has (had) CRD.

4 Individual age 65 or over entitled to Medicare on the basis of Old-Age Survivors Insurance or uninsured provision, also has (had) CRD.

8 Individual covered under premium Part A payment provision (Section 202) of P.L. 92-603, also has (had) CRD. (Carriers will not receive code 8.)

All of these codes are mutually exclusive.

Temporary query procedures for identifying CRD beneficiaries will be required beginning 7/1/73. Strict adherence by intermediaries in following these temporary procedures will assure early accretions of CRD beneficiary indicator codes to the HI Master Record. It is anticipated that the HI Master Record will have an indicator code for all enrolled or identified CRD beneficiaries by 10/1/73.

The facility will submit an SSA-2742 with the first admission notice or SSA-1483 (whichever is earlier) submitted for each patient the facility identifies as having CRD. Such patients will include the ones who have established Medicare entitlement (they have been issued Medicare HI cards) and ones who are in the process of establishing Medicare entitlement or could establish Medicare entitlement by filing an application with a social security office. The intermediary will query the admission notices and SSA-1483's received from facilities. It should be noted that the special bill review function for the SSA-1483 should be performed prior to the query step. See Section B.4. below.

a. If the SSA reply indicates Medicare entitlement and has an S trailer with a code 2, 3, 4, or 8 to identify the patient as a CRD beneficiary, the intermediary should perform the special bill review function and the special routing of material to BHI (See Section B.4. below) in addition to its regular bill processing procedures.

b. If the reply indicates Medicare entitlement but has no S trailer code to identify the patient as a CRD beneficiary, the intermediary should hold the bill, review the SSA-2742 in accordance with Section B.4.a. below, and immediately send the two SSA copies to SSA, BHI, P.O. Box 27, Baltimore, Maryland 21203. This instruction applies to admission notices as well as expense queries. The primary purpose for submitting the

SSA-2742 at this stage of bill processing is to permit SSA to place an indicator code in the HI Master Record for the beneficiary. After SSA has taken this step, an automatic notice, disposition code 39, will be sent the intermediary showing the proper CRD indicator code. When the automatic notice is received, the intermediary will then perform the special bill review function and special routing of material to BHI (See Section B.4. below) in addition to its regular bill processing procedures. If no SSA automatic response has been received within 30 days of the original query or by 10/1/73, whichever is later, the intermediary may submit its bills to SSA as it regularly does for any Medicare patient and disregard the special instructions in this I.L.

c. If the intermediary receives a reject notice, the intermediary should notify the local social security office about the reject notice and furnish sufficient identifying information for the social security office to investigate the eligibility of the patient. The intermediary should advise the social security office that the beneficiary is under age 65 and a potential CRD or disability insurance beneficiary. The social security office will advise the intermediary whether or not the patient is entitled to Medicare benefits. If the person is not entitled to Medicare benefits, the intermediary should deny the bill and send a beneficiary denial notice. If the person is entitled, the social security office will advise the intermediary when it may resubmit its query. When the query response is received from SSA, it will indicate the patient's Medicare entitlement as a CRD beneficiary and the intermediary will then perform the special bill review function and special routing of material to BHI (see section B.4. below) in addition to its regular bill processing procedures.

4. Intermediary Bill Processing Procedures.--When the intermediary has received an SSA reply on an admission notice or expense query which has a trailer indicator code identifying the patient as a CRD beneficiary, the procedures listed below apply.

a. The intermediary reviews the SSA-2742, Patient History form for proper completeness. (Note: such a review may have been done during the query process as outlined above. If so, this form has already been reviewed and SSA copies forwarded. If this is so, the intermediary copy is now used as a bill review tool.) If this form has not been submitted by the facility, the intermediary should immediately obtain it. The facility should have completed the SSA-2742 in accordance with the following instructions:

[Form not reproduced.]

SSA-2742, EXPLANATION OF THE MEDICARE CHRONIC RENAL DISEASE PATIENT HISTORY

The intermediary will make certain that the patient history form is received when the first notice of admission or SSA-1483 bill is submitted from a renal treatment facility (hospital or limited care facility) for a beneficiary who is identified as having chronic renal disease. The form should be submitted even though the renal treatment facility may have furnished only non-renal services as its first treatment when the beneficiary first becomes entitled to Medicare benefits. The patient's physician or the facility's medical record librarian or clerk will complete the form and forward it to the intermediary. Incomplete data forms will be developed by the intermediary. The SSA-2742 is a four-part form. It is distributed as follows:

Original and 1 copy to SSA, BHI, P.O. Box 27,

Baltimore, Maryland 21203

1 copy for the intermediary

1 copy for the facility

The intermediary should review the carbon copies and correct any distortions due to slippage or lack of legibility prior to submitting the original to BHI.

Only one form per patient is to be completed. If an intermediary is aware that this form has been previously obtained by another intermediary it does not need to obtain one. However, a copy may be requested from that intermediary when additional bills from the patient may be anticipated.

SSA reviews all Medicare bills for beneficiaries with CRD on a post-payment basis, and may request further detail from intermediaries about specific claims. All requests for additional information will be transmitted through the SSA regional offices.

Items appearing on the form:

1. Patient's Last Name, First Name, and Middle Initial.--Name must be taken from the patient's health insurance card.
2. Date of Birth.--Give the date in month, day, and year order, using a six-digit number, e.g., 03/31/00.
3. Sex.--The appropriate box should be checked.
4. HI Claim Number.--Claim number must be taken from the patient's health insurance card.
5. Current Provider of Services (Name and address (city and State)).--Enter name and address of the hospital or limited care facility currently providing services to the beneficiary or the facility supervising the patient on home dialysis.
6. Provider Number.--Enter the 6 position provider number assigned by SSA.
7. Intermediary Number.--Enter the intermediary number of the servicing intermediary for the provider given in item 5. If unknown to the facility, the intermediary will add this identification number before forwarding the history form to SSA.
8. Date Chronic Renal Disease Initially Evaluated.--Enter the date a physician experienced in dialysis and/or transplantation initially evaluated the patient.
9. Method of Diagnostic Confirmation (Check All Applicable).--If a method was used which is not listed, check "other" and specify in Remarks. Use standard medical terminology. Precede remark with this item number.
10. Primary Disease Leading to Chronic Renal Failure (Check One).--Check the appropriate diagnosis. If blocks J or K are checked, the complete diagnosis should be entered, using recognized terminology, e.g., as found in the International Classification of Diseases Adapted, Current Medical Terminology, Standard Nomenclature of Diseases and Operations.

Additional diagnoses leading to CRD include:

amyloidoses
cortical necrosis, bilateral
gouty nephropathy
hypoplastic kidney
myeloma kidney
medullary cystic disease (nephronophthisis)
oxalosis
cysterosis
thrombosis, renal arterial
thrombosis, renal venous
toxic nephropathy (specific agent #####)
radiation nephritis
traumatic or surgical loss of kidney
hemolytic-uremic syndrome
thrombotic thrombocytopenic purpura
embolic renal disease
tumor (specify #####)
medullary necrosis, bilateral

retroperitoneal fibrosis

11. Complicating Conditions Present in Addition to Primary Diagnosis (Check All Applicable).--Check all present major complicating conditions. Use standard medical terminology if items w or x are applicable (see item 10 above).
12. History of Dialysis Settings in Year Prior to Entitlement.--Indicate dates dialysis initiated for all dialysis settings in which the patient received treatment during the year prior to the date of Medicare entitlement. If no services given in any setting, check the block marked, "None." For beneficiaries entitled on July 1, 1973 or later, use 1 year prior to the date of Part A entitlement as shown on the Health Insurance Card. For beneficiaries entitled prior to July 1, 1973, use the period of time from 7/1/72 to 7/1/73. If services were given in a particular setting, but were given less frequently than weekly, enter "O." If services were given weekly, show the number of sessions given per week.
13. Setting for Current Dialysis (Check One).--Check the appropriate block for the setting at the time the history is completed. If the beneficiary is receiving dialysis treatment as a hospital inpatient, check the first block; if the beneficiary is receiving dialysis treatment in a hospital outpatient unit, check the second block. When dialysis is provided in a provider or non-provider facility that provides maintenance dialysis services only, with supervision and assistance provided to the patient, check the third block. When dialysis services are provided in a separate unit of a hospital or limited care facility with the patient generally caring for his own needs with minimal supervision, check the fourth block. When the patient is dialyzing at home, check the last block.
14. Current Plan Reviewed by Medical Review Board.--If the patient's plan of treatment was reviewed by a medical review board established by SSA, check yes. If not reviewed, check no. If the information is not available check unknown.
15. Date of First Dialysis.--This is the date the patient first received dialysis. It may be the same as or earlier than the date a course of regular dialysis began (item 17). It should be the very first date of dialysis, not the first dialysis in the current facility.
16. Type of First Dialysis.--Check hemodialysis or peritoneal.
17. Date Course of Regular Dialysis Began.--This is the date a regular course of dialysis began. This is one of the beginning dates for determining eligibility for Medicare coverage under the special provisions for patients with CRD.
18. Type of Current Dialysis.--Check hemodialysis or peritoneal.
19. Is Patient Approved For or Currently Receiving Self Dialysis Training.--Check the appropriate box.
20. If in Self Training, Will Patient Be Dialyzing At Home?--Check appropriate block.
21. If Self Dialyzing, But Not at Home, Check All Applicable.--Check all reasons that apply. If "Other" checked, specify in Remarks. Precede remarks with this item number.
22. If Not in Self Training, Check Applicable Block.--If "Other" specify in Remarks. Precede remarks with this item number.
23. Is Patient Transplant Candidate?--Check applicable block.
24. If Transplant Candidate, Enter Name of Center Where Transplant Will Be Performed.--Enter name of center and also show the center's provider number. If number not known, the intermediary will enter the provider number before submitting the form to SSA.
25. If Patient Transplant Candidate, Does He Have Living Donor?--Check applicable block.
26. If Patient Has No Living Donor, Is He On Register?--Check applicable block. If "Yes" give name of Register.
27. If Patient Is Not Transplant Candidate, Check All Applicable Blocks.--If "Other" block checked, specify in Remarks. Precede remarks with this item number.

28. Dates of Nephrectomy (own organ).--Enter in the appropriate space, the date the patient's natural right and/or left kidney was removed.
29. Total Number of Transplants (enter "O" if applicable).--Complete as applicable.
30. Date of Most Recent Transplant; Date of Second Most Recent Transplant; Date of Third Most Recent Transplant.--Complete as applicable. Use a 6 position date, e.g., 03/03/74.
31. Date of Other Surgical Procedures.--Indicate which, if any, of the listed surgical procedures were performed and the dates for each. If procedures related to chronic renal disease other than those listed were performed, specify the procedure(s) in "Other" and include proper date(s). See item 10 above as to type of terminology to be used in completing "Other" line.
32. Physician's Assessment of Patient's State of Health (Check One).--The 5 classifications follow the renal disease guidelines established by the American Heart Association.
33. Beneficiary Status (Check One).--If the patient works an average of 30 hours or more per week, he is considered a full time worker; if less than 30 hours per week, he is considered a part-time worker. If "other" is checked, specify in Remarks. Precede the remark with this item number.
34. Has Tissue Typing For Beneficiary Been Performed.--Check applicable "yes" or "no" block. If tissue typing has been performed, enter findings in each block A-C.
35. Remarks.--This space is used for detailed explanations of other items in the form or for any additional information which is pertinent to the patient's medical history.
36. Signature.--The signature of the patient's physician or the facility representative completing the patient history is entered. Enter the title of the person completing the form.
37. Date Signed.--Enter the date the form was completed.

b. In addition to the SSA-2742 form, the second special CRD form is the Medicare Chronic Renal Disease Charge and Service Information, SSA-2743, which is a supplement to the SSA-1453 or SSA-1483 bill. Unlike the patient history form, SSA-2742, which is submitted only once by the facility, the Charge and Service Information form, SSA-2743 is an ongoing supplemental bill form and is submitted with each bill. The primary purpose of the SSA-2743 is to breakout the charges by type of service for the renal treatment. Current billing forms do not lend themselves to the identification of special services furnished CRD patients. Therefore, these forms will be of immeasurable aid to the intermediary in its review function and to SSA in its post payment evaluation of services provided to CRD patients. The facility should complete the SSA-2743 in accordance with the following instructions.

[Form not reproduced.]

SSA-2743, MEDICARE CHRONIC RENAL DISEASE CHARGE AND SERVICE INFORMATION

This is a supplemental charge and service information sheet which must be attached to the SSA-1453 or SSA-1483 bills for beneficiaries identified as having chronic renal disease. The form requests a detailed breakdown of charges for specific line items on the associated billing form. This form is not used for carrier bills.

The purpose of the SSA-2743 is to define those services and charges which contribute to the overall cost of chronic renal disease. Intermediaries will obtain needed information where the facility has submitted incomplete or incorrect data.

The SSA-2743 is a four-part form. It is distributed as follows

Original and 1 copy to SSA, BHI, P. O. Box 27, Baltimore, Maryland 21203.

1 copy for the intermediary

1 copy for the facility

The intermediary should review the carbon copies and correct any distortions due to slippage or lack of legibility prior to submitting the original to BHI.

Items appearing on the SSA-2743:

1. Patient's Name.--Name must be taken from the patient's health insurance card.
2. HI Claim Number.--The patient's health insurance claim number as shown on his health insurance card.
3. Only Non-Renal Treatment Involved.--Check only if there were no services for dialysis, home dialysis equipment and supplies, kidney transplants, or routine or non-routine laboratory tests related to renal treatment furnished during the billing period. When this item is checked, complete only items 1 through 11. No charge information should be entered on the form as charge data is entered for renal treatment only.

If a non-renal treatment facility such as a skilled nursing facility or home health agency submits a bill for a CRD beneficiary, the intermediary should complete items 1-11, on behalf of the facility. SSA needs this data even though the services were non-renal.
4. Sex.--The appropriate box should be checked.
5. Date of Birth.--Show the date in month, day, and year order using a six-digit number, e.g., 05/10/09.
6. Admission Date (Inpatient Hospital).--If the patient is a hospital inpatient, enter the date of admission. (Should be the same as Item 7 on the SSA-1453.)
7. Statement Covers Period.--Enter the FROM and THRU dates of the period covered by the bill. These dates should correspond to Item 20 on the SSA-1453 and Item 16 on the SSA-1483.
8. Provider Number.--The provider's identification number.
9. Intermediary Number. The intermediary's identification number. The intermediary will enter this number if missing.
10. Complications of Chronic Renal Disease and/or Other Conditions (Diagnoses) Requiring Treatment.--List complications or diagnoses secondary to chronic renal disease which are present at the time of this billing. (Maximum of five.) Use standard terminology.
11. Surgical Procedures and Dates (Other than Transplants).--Surgical procedures performed during the billing period should be shown as entered in the patient's medical record, e.g., shunt revision. (Enter as maximum of 5.) Enter in the dates column, the month and day surgery was performed.
12. Dialysis Setting.--Check all settings in which dialysis occurred during the billing period in Item 7. Dialysis treatment furnished to a hospital inpatient, hospital outpatient, or by a limited care facility means maintenance dialysis services with significant supervision and assistance provided the patient. Self dialysis is defined as dialysis services provided in a separate unit of a hospital or limited care facility with the patient generally caring for his own needs with minimal supervision. When the beneficiary is in his home, check the home dialysis block. When training dialysis is involved check 12F. Information for Training Dialysis should be entered in line F in columns 14 - 19.
13. Usual Setting.--Check the beneficiary's usual setting for dialysis. Example 1. The beneficiary is usually on home dialysis but during the current billing period he received dialysis and tests as a hospital outpatient. In this situation, columns 12B and 13E would be checked. Example 2. The beneficiary is receiving training dialysis in an LCF. Check 12F and 13C.
14. Usual Time (Hrs.) --Enter the usual number of hours (rounded to the nearest hour) the beneficiary receives dialysis in each setting checked in Items 12.
15. Dates Dialyzed (Enter Month and Day).--Fourteen blocks are provided to enter the dates that dialysis occurred during the billing period. Include month and day. The dates are entered on the line corresponding to the dialysis setting in item 12 and must be in chronological sequence. In the home setting, item 15 may be omitted if the dates are not readily available. However, the number of times dialyzed (Item 16E) should be completed for dialysis in the home setting.
16. Total Sessions.--Enter total number of sessions for each setting checked in Item 12.

17. Total Hours.--Enter the total number of hours (rounded to the nearest hour), in each setting in Item 12 that dialysis occurred during the billing period.

18. Charge Per Dialysis.--Enter the charge per dialysis in each setting. For settings A-E, this entry should include only the straight dialysis charge. Specific non-routine professional service to the patient and any routine and non-routine laboratory service reported in Items 36A&B &37 should be excluded. For training sessions(F), include the additional training charge in the total dialysis charge. For patients receiving home dialysis, no entry is shown in this item.

19. Total Charge.--Enter the total charge for dialysis during the billing period in each setting. For patients receiving home dialysis, no entry is shown in this item.

HOME DIALYSIS INFORMATION

20. Type of Delivery System.--Check the appropriate block. If "Other" checked, specify the type.

21. Method of Payment.--Check applicable block to indicate whether the delivery system is being rented or purchased.

22. Monthly Rental Charge.--Enter the monthly amount for rental of the delivery system.

23. Total Purchase Price.--If the equipment is being purchased and the purchase occurred during the current billing period, enter the total charge for the delivery system.

24. Monthly Purchase Charge.--Enter the prorated monthly installment charge if the delivery system is being purchased.

25. Total Rental or Purchase Charges Billed to Date.--Enter the total charges (rental or purchase) covered by Medicare and billed to date.

26. Installation Charge.--Enter the total installation charge if the equipment was installed during the current billing period.

27. Supplies (including dialyzer), (Attach bill of lading or invoice).--Enter the prorated monthly charge for all disposable supplies such as the dialyzer, and ATTACH AN ITEMIZED BILL OF LADING OR INVOICE. If patient reuses dialyzers, enter this information in Remarks plus show the usual number of times a dialyzer is reused. Precede the information in Remarks by this item number.

TRANSPLANT INFORMATION

Complete items 28-33 only if a transplant was performed or a transplant nephrectomy and/or return to chronic dialysis was necessary during the billing period in Item 7.

28. Date of Transplant.--Enter the date of the kidney transplant if it occurred during the billing period. Also attach the hospital's itemized bill or ledger sheet for the provider component charges. The attachment should also cover the same billing period as shown in Item 7.

29. Date of Transplant Nephrectomy and/or Return to Chronic Dialysis.--If a previous kidney was rejected, enter the date of the transplant removal or if not removed, the date the patient was returned to chronic dialysis. The date of either of these events must be within the Statement Covers Period (Item 7).

30. Indicate Other Surgical Procedures Performed In Relation To Transplant.--Check all applicable procedures. If "Other" surgery was performed in connection with transplant, specify the procedures using standard terminology.

31. Source of Transplant Organ.--Check the appropriate block.

32. Kidney was Acquired.--(A.) Indicate whether the kidney (cadaveric or living donor) for transplant was acquired within the hospital where transplant occurred; or (B) From an outside source.

33. Kidney Acquisition Charge.--If a living donor, enter the standard living donor kidney excision charge whether acquired within the hospital or from an outside source. If cadaveric kidney, enter the standard cadaveric kidney excision charge whether acquired within the hospital or from an outside source.

34. Tissue Typing Charge.--Identify the donor and donee charges for tissue typing. Tissue typing charges include those performed for living or cadaveric donor, and post transplant. Tissue typing charges for the beneficiary should also be included even though a transplant was not performed.

35. Beneficiary Tissue Type.--Enter findings for each block. This item should be completed whether or not a transplant was performed.

36. Routine Laboratory Tests.--In block A, enter all laboratory charges for those routine laboratory services performed directly in the dialysis unit. Enter the number of tests performed and the total charge. Enter in block B, all laboratory charges for those routine laboratory services performed outside of the dialysis unit, i.e., in a hospital laboratory or independent laboratory. Indicate the number performed and the total charge. (See II.B.(3) (2) which defines routine laboratory tests.)

37. Non-Routine Laboratory Tests.--Enter all non-routine tests performed during the billing period. Indicate the type of test using standard terminology, the number given, the charge per test, and the total charge. If there are not sufficient lines, enter information in Remarks. These entries should be preceded by the applicable item number (37I-Z).

38. Remarks.--This space is reserved for any pertinent details which relate to charge and service information for CRD beneficiaries and for additional non-routine laboratory tests from Item 37.

c. Both SSA-2742 and SSA-2743 forms should be used by the intermediary during review of bills. The SSA-2743 should only reflect charges for covered services outlined in the coverage chapter of this I.L.

d. The sum of the charges listed on the SSA-2743 for a particular type of service may equal or be less than (if renal and non-renal treatment was furnished) the total entered on the line item on the bill. For example, the total of the individual charge entries for various laboratory tests for which a separate charge is recognized must be equal to or less than the total amount for laboratory charges entered on line 19N, Laboratory, on the SSA-1453 and on line 15C, Laboratory, on the SSA-1483. This is true of all breakout charges on the SSA-2743.

Where the SSA-1453 or SSA-1483 does not have a line item for a specific type of service, such charges should be entered on line 19T, Other, of the SSA-1453 and line 15I, Other, on the SSA-1483. For example, maintenance dialysis services furnished by a hospital outpatient department or an LCF would be billed on Line 15I, on the SSA-1483.

Charges for services furnished the beneficiary in connection with a kidney transplant excluding kidney excision charges should be entered on the appropriate lines in item 19, on the SSA-1453, in the same manner as is done for any other surgical procedures.

Enter the appropriate standard charge for kidney excision in item 19T, Other, on the SSA-1453. 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 19T, Other.

In addition, where the living donor or cadaveric kidney was obtained from outside the hospital, identify the outside source by name and address in item 30, Remarks on the SSA-1453.

See Part III, Reimbursement of Provider Facilities, for further information concerning the provider's standard charges to be used for billing for cadaveric kidney excisions and for living donor kidney excisions.

e. After the SSA-1453 or SSA-1483 and supplemental CRD forms have been reviewed and the bill paid, and before the usual batching and forwarding of bills to SSA, the intermediary will prepare an extra copy of the SSA-1453 or SSA-1483 bill, (either a photocopy or an unused copy of the bill), SSA's two copies of the SSA-2742 (if applicable) and SSA's two copies of the SSA-2743 should be securely stapled together for each beneficiary bill and sent on a daily basis to SSA, BHI, P.O. Box 27, Baltimore, Maryland 21203. The extra copy of the bill and related forms that are sent daily to BHI are in addition to the regular batching procedures. The regular bill batching procedures applicable to the Social Security Administration copy of the SSA-1453 and SSA-1483 will still be followed by the intermediary. It should be noted that the Patient History form may have been released earlier to BHI either because of the special requirements in the query procedures or because

a prior Patient History form had been submitted with an earlier bill. However, on an ongoing basis, there will always be an extra copy of the bill and the related Charge and Service Information form, SSA-2743, submitted separately to BHI.

f. The regular sample bill procedures applicable to SSA-1453's and SSA-1483's will still be followed and are totally separate from the special bill procedures applicable to CRD beneficiaries. Thus, if a CRD bill should happen to fall in the regular sample, the intermediary must follow its usual procedures for submitting sample bills without regard to the extra copy of the bill and related forms that are being sent to BHI.

5. Special Rules Regarding Billing for Physician Component.--See Parts on coverage and reimbursement for information on how physician services should be billed.

6. Special Rules for Laboratory Charges for Maintenance Dialysis Treatment.--Laboratory charges will be shown in the following manner on the SSA-2743 and applicable bill.

SSA-2743:

The dialysis charge entered in Item 18 on this form is exclusive of all laboratory charges. The routine laboratory charges (as defined in Part II.B.3.e) performed in the dialysis unit laboratory will be entered in Item 36A. The routine laboratory charges performed in a non-dialysis unit laboratory (for example, the hospital's separate laboratory department or any under arrangement laboratory services the hospital has) will be entered in Item 36B. If routine laboratory tests are performed more often than the defined frequency listed in Part II, B.3.e, such tests should be listed on the applicable line 36A or 36B with an explanation in Item 38, Remarks, justifying the need for the extra tests.

All laboratory tests other than those defined as routine laboratory tests will be identified and entered in Item 37.

SSA-1453 or SSA-1483:

The sum of the dialysis charge as entered in Items 19 and any dialysis unit laboratory charge shown in 36A on the SSA-2743 will be entered in the dialysis charge on the bill in line 19T, Other, on the SSA-1453 and in line 15I, Other, on the SSA-1483. Thus, the dialysis charge on the bill represents the straight dialysis charge, plus the routine laboratory charges that were done in the dialysis unit center. All other laboratory charges whether routine or non-routine are entered in line 19N, Laboratory, on the SSA-1453 or in line 15C, Laboratory on the SSA-1483.

7. Special Rules Regarding Billing for Durable Medical Equipment and Disposable Medical Supplies.--Where a facility, acting as a supplier, furnishes durable medical equipment and disposable medical supplies to a home dialysis beneficiary, the facility should submit an SSA-1483 for equipment and supplies in accordance with Part A Intermediary Manual, Section 3642. No other services should be included on an equipment and supplies SSA-1483.

8. Special Rules Regarding Bills Received From Non-Renal Treatment Facilities.--The special procedures in this I.L. will apply to bills received from non-renal treatment facilities (such as skilled nursing facilities or home health agencies) only where the patient is identified by the SSA query response as being a CRD beneficiary. When such a situation occurs, the intermediary partially completes the SSA-2743, (see instructions for completing this form) and sends an additional copy of the bill to SSA, BHI, as instructed in Part VII.B.4.ff. in addition to following its regular bill processing procedures.

9. Limited Care Facility Erroneously Files SSA-1490's With Carrier.--Carriers are instructed to transfer SSA-1490's erroneously filed by limited care facilities to intermediaries for handling (see Part VII,C). If such bills are received from carriers, intermediaries should obtain properly completed SSA-1483's in accordance with instructions in Part A Intermediary Manual, Section 3640.9.

C. Special CRD Bill Processing Procedures Applicable to Carriers.--Special CRD bill processing procedures also apply to carriers as explained in Section A of this chapter.

Carriers will receive SSA-1490 (or SSA-1556, SSA-1554) bills from physicians, suppliers, independent laboratories, and beneficiaries for services furnished CRD beneficiaries.

Effective, 7/1/73, limited care facilities will no longer be permitted to bill on SSA-1490's to carriers. As of that date and thereafter, LCF's bills will be processed by intermediaries. Carriers should take the necessary steps to block the processing of SSA-1490's received from an LCF for services rendered on or after 7/1/73.

If such bills are received after the effective date of this change, the carrier should transfer the SSA-1490 to the intermediary servicing the LCF so that the intermediary can contact the LCF regarding the proper billing procedures. If the servicing intermediary is unknown to the carrier, the facility should be contacted to ascertain its hospital affiliation. During any such contact the carrier should explain the new procedure to the facility and at the same time advise the facility of the name and address of its intermediary. The carrier should attach an explanation to the SSA-1490 bills to explain why they are being transferred to the intermediary. The intermediary will then obtain properly completed SSA-1483's from the facility for the services erroneously billed on the SSA-1490's.

1. Carrier Query Procedures.--See Section B.3., Intermediary Query Procedures, for a general explanation and the fact that some of SSA query replies as of 7/1/73, will not have an indicator code identifying the patient as a CRD beneficiary or that a health insurance record may not yet be established. A list of the S trailer indicator codes are in Section B.3.

In most cases when the carrier queries, the SSA query response will identify the patient as a CRD beneficiary since an intermediary will probably have processed a form SSA-2742 received from a facility, or SSA has set the indicator code through other means. However, a beneficiary on home dialysis who has, independent of a hospital or limited care facility, arranged for durable medical equipment and disposable medical supplies, may not be identified on SSA's record as a CRD beneficiary.

Where the bill shows end-stage chronic renal disease, carriers will apply the special bill review procedures listed in earlier parts of the I.L. regarding coverage and reimbursement guidelines before following the special query procedures listed below.

Carriers should apply these special query procedures even if their internal record establishes that the deductible has been met. These special query procedures apply only to bills which clearly show treatment for end-stage chronic renal disease. For carrier purposes, treatment for end-stage chronic renal disease is defined as services, supplies, and/or equipment involving maintenance dialysis or kidney transplant, only. Such a bill may be filed by a beneficiary, a physician, a supplier, or an independent laboratory; it does not include a bill filed by a limited care facility. These special query procedures are necessary to confirm that SSA has identified the beneficiary as a CRD patient.

a. If the carrier's internal record establishes that the deductible has been met and the bill does not indicate end-stage disease, none of the special procedures in this I.L. apply. However, where the bill does not indicate end-stage renal disease but the carrier has to query and the query response has an S trailer indicating CRD involvement, the following procedures apply:

the carrier should review the bill again in accordance with coverage and reimbursement guidelines listed in earlier parts of this I.L.,

the carrier should complete its regular bill processing procedures, and follow the instructions in Part VII(C)(2) ff. in forwarding material to BHI.

b. If the SSA query response indicates Medicare entitlement without the CRD indicator for these end-stage renal disease bills, the carrier should hold the bill and request a Patient History form, SSA-2742, (see Part VII.B.3. ff. for a full explanation of this form) from the facility supervising the patient's renal treatment, regardless of who filed the bill. The carrier may obtain the name of the facility from the beneficiary and call the facility to request the SSA-2742 (all renal treatment facilities will stock this form). (The other renal form, SSA-2743, Medicare Chronic Renal Disease Charge and Service Information, is never submitted for carrier bills.) As soon as the SSA-2742 is received from the facility and after review in accordance with Part VII.B.4.a., the carrier will immediately mail SSA's two copies of the SSA-2742 to SSA, BHI, P.O. Box 27, Baltimore, Maryland 21203. This will permit SSA to place the indicator in the HI Master Record for the beneficiary. After SSA has taken this step,

an automatic notice will be sent to the carrier to show the proper S trailer indicator code. When the automatic notice is received, the carrier will then follow the special routing of material to BHI (see Section C(2)ff. below) in addition to its regular bill processing procedures. If no SSA automatic response has been received within 30 days from the date the original query was sent to BHI or by 10/1/73, whichever is later, the carrier may finish processing the bill as it regularly does for any Medicare patient and disregard the special instructions in this I.L.

c. If the carrier receives a reject notice, the carrier should notify the servicing social security office about the reject notice and furnish sufficient identifying information for that office to investigate the eligibility of the patient. The carrier should also advise the social security office that the beneficiary is under age 65 and a potential CRD or disability insurance beneficiary. The social security office will advise the carrier whether or not the patient is entitled to Medicare benefits. If the person is not entitled to Medicare, the carrier should deny the bill and advise the beneficiary of such non-eligibility. If the person is entitled, the social security office will advise the carrier when it may resubmit its query. The query response from SSA should indicate the patient's Medicare entitlement as a CRD beneficiary and the carrier will follow the special procedures regarding coverage and reimbursement and routing of material to BHI (see Section 2 below), before completing its usual bill processing steps.

2. Carrier Claims Processing Procedures.--The carrier will perform the following special CRD bill review functions:

a. For physician services, follow instructions in earlier parts of this I.L. concerning coverage and reimbursement for physician services.

b. For independent laboratory services, follow instructions in earlier parts of this I.L. concerning coverage and reimbursement of laboratory services.

c. As a temporary procedure, SSA will permit the home dialysis beneficiary or supplier on assignment to bill on the SSA-1490 for such equipment and supplies, but permanent SSA procedures may require the hospital or limited care facility (LCF) to take over the billing for the home dialysis patient. See earlier parts of this I.L. for an explanation of equipment, supplies, installation charges, etc., which are covered under the program and the type of bill review that should be given these bills. In processing these equipment and supplies SSA-1490's, the carrier should request a bill of lading (invoice) to provide the detail of supplies furnished. The carrier should obtain information as to the number of dialysis treatments the supplies will cover and document this on the SSA-1490 or on the attachment. Some suppliers customarily ship several months supplies at one time to home dialysis patients. Such supplies should be reimbursed on a monthly usage basis. It will be necessary to obtain from the beneficiary the number of dialysis treatments received for the month and document this on the SSA-1490 in order to allocate the supplies on a monthly basis. Home dialysis beneficiaries (or suppliers on assignment) should be requested to bill monthly to reduce the number of bills filed for maintenance dialysis.

d. When the carrier has received an SSA query response which has a trailer indicator code identifying the patient as a CRD beneficiary or an automatic code 39, the following procedures apply: To enable BHI to obtain full CRD data to evaluate program costs and utilization as explained in Section A of this Part, carriers are required to submit a copy of the SSA-1490, SSA-1554, and SSA-1556 and all attachments. Bills should show any reduction in charges as is done for a sample bill. The carrier must include the carrier control number on the SSA-1490 (SSA-1554, SSA-1556) to permit SSA to match the information coded by SSA from the copies of the bills to the corresponding payment records. Copies of all SSA-1490's (SSA-1554's, SSA-1556's) for CRD beneficiaries (once identified to the carrier) must be copied and submitted regardless of whether or not a particular request for payment is for renal disease treatment.

e. The regular sample bill procedure will still be followed and is totally independent from the special CRD beneficiary material submitted to BHI for the evaluation study even where it may require double submittal of papers for a CRD beneficiary falling in the regular sample.

f. The regular procedures for submitting payment records are to be followed.

D. BHI Evaluation Survey of the CRD Category.--As explained in the preceding sections in Part VII, BHI will maintain a complete patient history file for each CRD beneficiary after receipt of copies of Medicare bills, SSA-2742 and SSA-2743 forms.

The patient history form (SSA-2742) is the basic document for each CRD beneficiary file and will be used by BHI in its post payment review of claims. The history form provides background information useful in determining the patient's general physical condition and the propriety of type and level of continuing treatment. BHI's capture of data from all claims for renal beneficiaries will also provide statistical data needed to determine the program cost of providing medical care in various settings for this catastrophic illness and to describe these beneficiaries' personal, demographic and medical characteristics. The patient history form is the basis of the intermediary review function, the subsequent post review at SSA, and the basis of the statistical system which will identify and describe the CRD population. SSA will update the patient history file based on processed bills including the Charge and Service Information form and may periodically request additional information from the intermediary and facility. Aberrant patterns detected from SSA's analysis will be called to the attention of the Medical Review Boards for their information and investigation.

If the data submitted to BHI is incomplete or the required data is not received, the intermediary or carrier will be instructed to submit the missing information.

This evaluation will be continuing for an indefinite time period.

* The term "limited care facility" generally refers to an off-hospital-premises facility, regardless of whether it is provider or non-provider operated, which is engaged primarily in furnishing maintenance dialysis services to stabilized patients.

** The facility may bill the patient the Part B deductible and coinsurance; such copay amounts plus program payment would together not exceed what is determined to be the facility's reasonable charge.

*** The intermediary should obtain such justification for each cost component which appears out-of-line. (Where the dialysis amount is in issue, mark the word Issue plainly in the upper right hand corner of the questionnaire.)