CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1999	**Date: July 9, 2010**
	Change Request 7003

This transmittal is no longer sensitive, is also being revised and re-issued November 24, 2010. The transmittal number and original date issued will remain the same. The instruction is being revised to allow Medicare contractors the authority to waive the monthly visit requirement for the home dialysis MCP service on a case by case basis. This instruction may now be posted to the Internet.

SUBJECT: ESRD Home Dialysis MCP

I. SUMMARY OF CHANGES: Effective January 1, 2011, the End Stage Renal Disease (ESRD) monthly capitation payment (MCP) physician (or practitioner) must furnish at least one face-to-face patient visit per month for the home dialysis MCP service. Chapter 8, section 140.1.1 was revised to reflect this change.

Additionally, references to the ESRD MCP "G codes" were removed from chapter 8, section 140.1.2.

EFFECTIVE DATE: January 1, 2011
IMPLEMENTATION DATE: January 3, 2011

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	8/140.1.1/Payment for Managing Patients on Home Dialysis
R	8/140.1.2/Patients Who Switch Modalities (Center to Home and Vice Versa)

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1999	Date: July 9, 2010	Change Request: 7003

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SUBJECT: ESRD Home Dialysis MCP

Effective Date: January 1, 2011

Implementation Date: January 3, 2011

I. GENERAL INFORMATION

A. Background: In the CY 2004 physician fee schedule (PFS) final rule published November 7, 2003 (68 FR 63216), CMS established new G codes for the end stage renal disease (ESRD) monthly capitation payment (MCP). For center-based patients, payment for the G codes varied based on the age of the beneficiary and the number of face to face visits furnished each month (e.g. 1 visit, 2-3 visits and 4 or more visits). Under this methodology, the lowest payment amount applies when a physician provides one visit per month; a higher payment is provided for two to three visits per month. To receive the highest payment amount, a physician would have to provide at least four ESRD related visits per month. However, payment for the home dialysis MCP only varied by the age of beneficiary. CMS stated that "we will not specify the frequency of required visits at this time but expect physicians to provide clinically appropriate care to manage the home dialysis patient."

Effective January 1, 2009, the CPT Editorial Panel created CPT codes to replace the G codes for monthly ESRD-related services (and CMS accepted the new codes). The clinical vignettes used for the valuation of the home dialysis MCP services (as described by CPT codes 90963 through 90966) include scheduled (and unscheduled) examinations of the ESRD patient.

B. Policy: Effective January 1, 2011, the MCP physician (or practitioner) must furnish at least one face-to-face patient visit per month for the home dialysis MCP service as described by CPT codes 90963, 90964, 90965, and 90966. Documentation by the MCP physician (or practitioner) should support at least one face-to-face encounter per month with the home dialysis patient. However, Medicare contractors may waive the requirement for a monthly face-to-face visit for the home dialysis MCP service on a case by case basis; for example, when the nephrologist's notes indicate that the physician actively and adequately managed the care of the home dialysis patient throughout the month.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7003.1	Medicare contractors shall make payment for the home dialysis MCP service as described by HCPCS codes 90963 – 90966.	X			X						
7003.1.1	Medicare contractors should waive the requirement for a monthly face-to-face visit for the home dialysis MCP service on a case by case basis.	X			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7003.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X			X						

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:
7003.1	Medicare contractors should periodically review documentation by the MCP physician (or practitioner) supporting a face-to-face interaction during the month with the home dialysis patient.

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

V. CONTACTS

Pre-Implementation Contact(s):

Erin Smith; 410-786-0763; Erin.Smith@cms.hhs.gov

Post-Implementation Contact(s):

Appropriate Regional Office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

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

Section B: *For Medicare Administrative Contractors (MACs):*

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

140.1.1 - Payment for Managing Patients on Home Dialysis

(Rev.1999, Issued: 07-09-10, Effective: 01-01-11, Implementation: 01-03-11)

Physicians and practitioners managing ESRD patients who dialyze at home are paid a single monthly rate based on the age of the beneficiary. *The MCP physician (or practitioner) must furnish at least one face-to-face patient visit per month for the home dialysis MCP service. Documentation by the MCP physician (or practitioner) should support at least one face-to-face encounter per month with the home dialysis patient. Medicare contractors may waive the requirement for a monthly face-to-face visit for the home dialysis MCP service on a case by case basis, for example, when the nephrologist's notes indicate that the physician actively and adequately managed the care of the home dialysis patient throughout the month.* The management of home dialysis patients who remain a home dialysis patient the entire month should be coded using the ESRD-related services for home dialysis patients HCPCS codes.

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

(Rev.1999, Issued: 07-09-10, Effective: 01-01-11, Implementation: 01-03-11)

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

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

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