CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2905	**Date: March 14, 2014**
	Change Request 8579

SUBJECT: Update to Pub. 100-04, Chapters 7 and 8 to Provide Language-Only Changes for Updating ICD-10 and ASC X12

I. SUMMARY OF CHANGES: This CR contains language-only changes for updating ICD-10 and ASC X12 language in Pub 100-04, Chapters 7 and 8. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

EFFECTIVE DATE: October 1, 2014
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 1, 2014

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	7/30/ Billing Formats
R	7/60/ Billing for Durable Medical Equipment (DME), Orthotic/Prosthetic Devices, and Supplies (including Surgical Dressings)
R	7/60.1/ Billing
R	7/60.3/ Billing for Enteral and Parenteral Nutritional Therapy as a Prosthetic Device
R	7/80.2/ Mammography Screening
R	8/10.5/ Hospital Services
R	8/20.1/ Calculation of the Basic Case-Mix Adjusted Composite Rate and the ESRD Prospective Payment System Rate
R	8/50/ In-Facility Dialysis Bill Processing Procedures
R	8/50.3/ Required Information for In-Facility Claims Paid Under the Composite Rate and the ESRD PPS
R	8/50.6.2/ Payment for Hemodialysis Sessions
R	8/50.7/ Ultrafiltration
R	8/60.1/ Lab Services
R	8/60.2.1.1/ Separately Billable ESRD Drugs
R	8/60.2.4.2/ Physician Billing Requirements to the Carrier
R	8/60.4.2.1/ Other Information Required on the Form CMS-1500 for Epoetin Alfa (EPO
R	8/60.4.6.1/ Other Information Required on the Form CMS-1500 for Darbepoetin Alfa (Aranesp)
R	8/80.2/ General Intermediary Bill Processing Procedures for Method I Home Dialysis Services
R	8/100.3/ Physician’s Services Furnished to a Dialysis Patient Away From Home or Usual Facility
R	8/130/ Physicians and Supplier (Nonfacility) Billing for ESRD Services/General
R	8/140.3/ Data Elements Required on Claim for Monthly Capitation Payment

III. FUNDING:

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 obliged 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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2905	Date: March 14, 2014	Change Request: 8579

SUBJECT: Update to Pub. 100-04, Chapters 7 and 8 to Provide Language-Only Changes for Updating ICD-10 and ASC X12

EFFECTIVE DATE: October 1, 2014
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 1, 2014

I. GENERAL INFORMATION

A. Background: This CR contains language-only changes for updating ICD-10 and ASC X12 language in Pub 100-04, Chapters 7 and 8.

B. Policy: There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8579.1	A/B MACs shall be aware of the updated language in Pub. 104, Chapters 7 and 8, for ICD-10 and for ASC X12.	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Not Applicable, 123-456-7890

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

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

Medicare Claims Processing Manual

Chapter 7 - SNF Part B Billing (Including Inpatient Part B and Outpatient Fee Schedule)

30 - Billing Formats

(Rev.2905, Issued: 03-14-14, Effective: 10-01-14, Implementation: 10-01-14)

The SNF must use the current *ASC X12 837 institutional claim format or if permissible* Form CMS-1450 to bill for covered Part B services. Instructions for those formats are located in the Medicare Claims Processing Manual, Chapter 25, "Completing *and Processing the CMS-1450* Data Set."

60 - Billing for Durable Medical Equipment (DME), Orthotic/Prosthetic Devices, and Supplies (including Surgical Dressings)

(Rev.2905, Issued: 03-14-14, Effective: 10-01-14, Implementation: 10-01-14)

A SNF may not bill for DME furnished to its Part A inpatients as necessary DME must be supplied to the beneficiary as part of SNF services. A SNF may not bill for DME furnished to its Part B inpatients or outpatients. However, a SNF may qualify as a supplier and enroll with the National Supplier Clearinghouse. In such cases, the SNF is given a separate supplier number to bill outpatient DME to the DMERC. The DMERC will furnish billing guidelines and payment will be made directly to the SNF as a supplier.

The SNF or other entity that furnishes prosthetic and/or orthotic devices to SNF residents for whom Part A benefits are not payable (no Part A entitlement or benefits exhausted) and for SNF outpatients may bill for such items. The SNF bills the intermediary. Suppliers bill the carrier or DMERC. See Chapter 20 for DMEPOS billing requirements, including definition of "supplier."

Prosthetic and orthotic devices are:

- Prosthetic devices (other than dental) that replace all or part of an internal body organ (including connective tissue) or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repair of such devices (see the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Service," §120); and

- Leg, arm, and neck braces, trusses, and artificial legs, arms, and eyes, including adjustments, repairs, and replacement required because of breakage, wear, loss, or a change in the patient's physical condition (see the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Service," §130).

SNFs bill supplies to its intermediary for outpatients.

60.1 - Billing

(Rev.2905, Issued: 03-14-14, Effective: 10-01-14, Implementation: 10-01-14)

The SNF must bill the intermediary for prosthetic/orthotic devices, supplies and surgical dressings *using the ASC X12 837 institutional claim format or if permissible Form CMS-1450*. Requirements for billing can be found in the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the CMS 1450 Data Set."

The SNF must bill prosthetic and orthotic devices under revenue code 274, along with the appropriate HCPCS code. When billing for maintenance and servicing of these items, revenue code 274 along with the appropriate HCPCS code must be used.

The SNF should report "Units of Service" on Form CMS-1450 the number of items billed to the SNF's intermediary for orthotics and prosthetics.

Supplies may be billed for SNF outpatients under revenue code 270. Payment is made based on a fee schedule.

The SNF should bill the intermediary for surgical dressings under revenue code 623. HCPCS codes for reporting surgical dressing are normally found in the Level II HCPCS codes in the A6000 series. The intermediary makes payment based on the surgical dressing fee schedule.

SNFs use 22X type of bill for orthotic and prosthetic devices and surgical dressings when billing for its Part B inpatients. Orthotic and prosthetic devices, surgical dressings, and supplies for outpatients are billed with 23X type of bill.

(See the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Service," §100 for coverage data.)

60.3 - Billing for Enteral and Parenteral Nutritional Therapy as a Prosthetic Device

(Rev.2905, Issued: 03-14-14, Effective: 10-01-14, Implementation: 10-01-14)

Parenteral nutritional (PEN) therapies including the necessary equipment, medical supplies and nutrients provided to an inpatient (where Part A payment cannot be made), or to individuals who are not inpatients are covered as a prosthesis under the Part B prosthetic device benefit as long as the requirements in the Coverage Manual are met, and the required documentation is submitted.

The SNF or the supplier must bill the DMERC. The SNF or supplier should refer to the most recent HCPCS directory or billing instructions distributed by the DMERC for current HCPCS coding information. If the SNF bills the DMERC, it must obtain a supplier number from the National Supplier Clearinghouse and must *use the ASC X12 837 professional claim format, or if permissible Form CMS-1500*.

Billing Instructions are in the Medicare Claims Processing Manual, Chapter 26, "Completing *and Processing the* Form CMS-1500 *Data Set*."

DMERC jurisdictions are based on the residence of the beneficiary. The DMERC for each State is shown on the CMS Web site at http://www.cms.hhs.gov/medicare/medicare-contracting/medicare-administrative-contractors/medicareadministrativecontractors.html .

80.2 - Mammography Screening

(Rev.2905, Issued: 03-14-14, Effective: 10-01-14, Implementation: 10-01-14)

Section 4163 of the Omnibus Budget Reconciliation Act of 1990 added §1834(c) of the Act to provide for Part B coverage of mammography screening for certain women entitled to Medicare for screenings performed on or after January 1, 1991. The term "screening mammography" means a radiologic procedure provided to an asymptomatic woman for the purpose of early detection of breast cancer and includes a physician's interpretation of the results of the procedure. Unlike diagnostic mammographies, there do not need to be signs, symptoms, or history of breast disease in order for the exam to be covered.

The technical component portion of the screening mammography should be billed on *the ASC X12 837 institutional claim format or if permissible Form CMS-1450* under bill type 22X for SNF Part A and Part B

inpatients or 23X for SNF outpatients. Claims for mammography screening should include only the charges for the screening mammography.

Medicare Claims Processing Manual
Chapter 8 - Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims

10.5 - Hospital Services
(Rev.2905, Issued: 03-14-14, Effective: 10-01-14, Implementation: 10-01-14)

Outpatient dialysis services for a patient with acute kidney failure or chronic kidney failure but not eligible for Medicare under the ESRD provisions at the time services are rendered must be billed by the hospital and cannot be billed by a Medicare certified renal dialysis facility on bill type 72x.

Hospitals with a Medicare certified renal dialysis facility should have outpatient ESRD related services billed by the hospital-based renal dialysis facility on bill type 72x. Hospitals that do not have a Medicare certified renal dialysis facility may bill for outpatient emergency or unscheduled dialysis services. The composite rate is not paid. For more information regarding the outpatient hospital billing policy for ESRD related services, see chapter 4 section 210 of this manual.

When an individual is furnished outpatient hospital services and is thereafter admitted as an inpatient of the same hospital due to renal failure - within 24 hours for non PPS hospitals and within 72 hours for PPS hospitals - the outpatient hospital services furnished are treated as inpatient services unless the patient does not have Part A coverage. Charges are reported on *the ASC X12 837 institutional claim format or on* Form CMS-1450. The day on which the patient is formally admitted as an inpatient is counted as the first inpatient day. The composite rate is not paid.

20.1 - Calculation of the Basic Case-Mix Adjusted Composite Rate and the ESRD Prospective Payment System Rate
(Rev.2905, Issued: 03-14-14, Effective: 10-01-14, Implementation: 10-01-14)

A case mix methodology adjusts the composite payment rate based on a limited number of patient characteristics. Variables for which adjustments will be applied to each facility's composite rate include age, body surface area (BSA), and low body mass index (BMI). These variables are determined in the ESRD PRICER to calculate the final composite rate (including all other adjustments).

The following table contains claim data required to calculate a final ESRD composite rate and the ESRD PPS rate:

Form CMS-1450	**ASC X12 837 institutional claim**
Through Date	2300 | DTP segment | 434 qualifier
Date of Birth	2010BA | DMG02
Condition Code (73 or 74)	2300 | HI segment | BG qualifier
Value Codes (A8 and A9) / Amounts	2300 | HI segment | BE qualifier
Revenue Code (0821, 0831, 0841, 0851, 0880, or 0881)	2400 | SV201

For claims with dates of service on or after January 1, 2011, Medicare systems must pass the line item date of service dialysis revenue code lines when the onset of dialysis adjustment is applicable to one or more of the dialysis sessions reported on the claim.

Form CMS-1450	**ASC X12 837 institutional claim**
Line Item Date of Service for Revenue Code (0821, 0831, 0841,	2400 | DTP Segment | D8 qualifier

0851	

In addition to the above claim data, the following payer only codes are required on claims with dates of service on or after January 1, 2011 to calculate the final ESRD PPS rate:

Form CMS-1450	**ASC X12 837 institutional claim**
Payer Only Condition Codes (MA, MB, MC, MD, ME, MF)	2300 | HI segment | BG qualifier
Payer Only Value Code (79)	2300 | HI segment | BE qualifier

Note: These payer only codes above are assigned by the Medicare standard systems and are not submitted on the claim by the provider. Payer only condition codes are only applicable when the appropriate corresponding diagnosis code(s) appears on the claim.

See information below in this section on co-morbidy diagnostic categories. The payer only value code 79 represents the dollar amount for services applicable for the calculation in determining an outlier payment.

The following provider data must also be passed to the ESRD PRICER to make provider-specific calculations that determine the final ESRD rate:

Field	**Format**
Actual Geographic Location MSA	X(4)
Actual Geographic Location CBSA	X(5)
Special Wage Index	9(2)V9(4)
Provider Type	X(2)
Special Payment Indicator	X(1)

In addition to the above provider data, the following is required to calculate the final ESRD PPS rate effective January 1, 2011:

Field	**Format**
Blended Payment Indicator	X(1)
Low-Volume Indicator	X (1)

Effective January 1, 2012 the following is required to calculate the Quality Incentive Program adjustment for ESRD facilities:

Field	**Format**
Quality Indicator Field	X(1)

ESRD facilities may elect to be reimbursed 100 percent by ESRD PPS no later than November 1, 2010. Facilities that do not elect to be reimbursed 100 percent by the ESRD PPS will be reimbursed by a blended payment rate which is composed of the current basic case-mix adjusted composite rate payment system and the new ESRD PPS.

Blended payment schedule:

Calendar year 2011 – 75 percent of the old payment methodology and 25 percent of new ESRD PPS payment

Calendar year 2012 – 50 percent of the old payment methodology and 50 percent of the new ESRD PPS payment

Calendar year 2013 – 25 percent of the old payment methodology and 75 percent of the new ESRD PPS payment

Calendar year 2014 – 100 percent of the ESRD PPS payment

Based on the claim and provider data shown above, the ESRD PRICER makes adjustments to the facility specific base rate to determine the final composite payment rate. The following factors are used to adjust and make calculations to the final payment rate:

Provider Type	Drug add-on	Budget Neutrality Factor
Patient Age	Patient Height	Patient Weight
Patient BSA	Patient BMI	BSA factor
BMI factor	Condition Code 73 adjustment (if applicable)	Condition Code 74 adjustment (if applicable)

In addition to the above adjustments, the following adjustments may be applicable to the ESRD PPS base rate for **adult** patient claims with dates of service on or after January 1, 2011:

Onset of Dialysis	Patient Co-morbidities	Low-Volume ESRD Facility

Onset of Dialysis:

Providers will receive an adjustment to the ESRD PPS base rate for patients within the initial 120 calendar days from when an ESRD beneficiary began their maintenance dialysis. The provider does not report anything on the claim for this adjustment. The adjustment is determined by the start date of dialysis in the Common Working File as reported on the patient's 2728 form. When the onset of dialysis adjustment is provided, the claim is not entitled to a co-morbidity adjustment or a training add-on adjustment.

Co-morbidity Adjustment Categories

The ESRD PPS will provide adjustments for 6 categories of co-morbidity conditions, 3 categories of chronic conditions and 3 categories of acute conditions. **In the event that more than one of the co-morbidity categories is present on the claim, the claim will be adjusted for the highest paying co-morbidity category.**

Acute Co-morbidity Diagnostic Categories:

The acute co-morbidity categories will be eligible for a payment for the first month reported and the following 3 consecutive months. Acute co-morbidity conditions reported for more than 4 consecutive months will not receive additional payment. In the event that the co-morbidity condition was resolved and later reoccurred, the provider may submit a condition code to indicate the diagnosis is a reoccurrence. The adjustment will be applicable for an additional 4 months.

Acute Categories are:

- Gastro-intestinal tract bleeding
- Bacterial pneumonia
- Pericarditis

Chronic Co-morbidity Diagnostic Categories:

When chronic co-morbidity codes are reported on the claim an adjustment may be made for as long as the chronic condition remains applicable to the patient care provided and is reported on the claim.

Chronic Categories are:

- Hereditary hemolytic or sickle cell anemia
- Monoclonal gammopathy
- Myelodysplastic syndrome

Information related to the comorbid conditions eligible for adjustment can be found at the **following website:** http://www.cms.gov/ESRDPayment/40_Comorbidity_Conditions.asp#TopOfPage. . This list may be updated as often as quarterly in January, April, July and October of each year.

Low-Volume Facilities:

ESRD facilities will receive an adjustment to their ESRD PPS base rate when the facility furnished less than 4,000 treatments in each of the three cost report years preceding the payment year and has not open, closed, or received a new provider number due to a change in ownership during the 3 years preceding the payment year. The ESRD facility must notify their Medicare Contractor if they believe they are eligible for the low-volume adjustment. Contractors must validate the eligibility and update the provider specific file. Pediatric patient claims are not eligible for the low-volume adjustment.

Medicare contractors are instructed to validate the facility's eligibility for the low volume adjustment. If a Medicare contractor determines that an ESRD facility has received the low volume adjustment in error, the contractor is required to adjust all of the ESRD facility's affected claims to remove the adjustment within 6 months of finding the error.

In addition to the above adjustments, the following adjustments may be applicable to the ESRD PPS base rate for **adult and pediatric** patient claims with dates of service on or after January 1, 2011:

Training Adjustment: The ESRD PPS provides a training add-on of $33.44 adjusted by the geographic area wage index that accounts for an hour of nursing time for training treatments. The add-on applies to both PD and HD training treatments**.**

ESRD PPS Outlier Payments:

Outlier payments may be applied to the payment. ESRD outlier services are the following items and services that are included in the ESRD PPS bundle: (1) ESRD-related drugs and biologicals that were or would have been prior to January 1, 2011, separately billable under Medicare Part B; (2) ESRD-related laboratory tests that were or would have been, prior to January 1, 2011 separately billable under Part B; (3) medical/surgical supplies, including syringes, used to administer ESRD-related drugs that were or would have been prior to January 1, 2011, separately billable under Medicare Part B; and (4) renal dialysis service drugs that were or would have been, prior to January 1, 2011 covered under Medicare Part D. ESRD-related oral only drugs are delayed until January 1, 2014. Services not included in the PPS that remain separately payable are not considered outlier services.

When the ESRD PRICER returns an outlier payment, the standard systems shall display the total applicable outlier payment on the claim with value code 17.

Information related to the outlier services eligible for adjustment can be found at the following website: http://www.cms.gov/ESRDPayment/30_Outlier_Services.asp#TopOfPage. This list may be updated as often as quarterly in January, April, July and October of each year.

For claims submitted with dates of service on or after January 1, 2012, all drugs reported on the ESRD claim under revenue codes 0634, 0635 and 0636 with a rate available on the ASP file will be considered in the Medicare allowed payment (MAP) amount for outlier consideration with the exception of any drugs reported with the AY modifier and drugs included in the original composite rate payment system.

Value Codes and Amounts

48 - Hemoglobin Reading - Code indicates the most recent hemoglobin reading taken before the start of this billing period. This is usually reported in three positions with a decimal. Use the right of the delimiter for the third digit.

The blood sample for the hemoglobin reading must be obtained before the dialysis treatment. If a hemoglobin value is not available facilities must report the value 99.99.

49 - Hematocrit Reading - Code indicates the most recent hematocrit reading taken before the start of this billing period. This is usually reported in two positions (a percentage) to the left of the dollar/cents delimiter. If the reading is provided with a decimal, use the position to the right of the delimiter for the third digit.

The blood sample for the hematocrit reading must be obtained before the dialysis treatment. If a hematocrit value is not available facilities must report the value 99.99.

50 - In-Facility Dialysis Bill Processing Procedures

(Rev.2905, Issued: 03-14-14, Effective: 10-01-14, Implementation: 10-01-14)

General instructions for *completing the claim* are in Chapter 25. The following instructions apply to facility reporting of ESRD services and to FI processing of in-facility dialysis claims.

The shared system checks the Common Working File (CWF) to determine if there is Employer Group Health Plan (EGHP) insurance. Where the beneficiary is covered under the EGHP insurance, see the Medicare Secondary Payer Manual.

50.3 - Required Information for In-Facility Claims Paid Under the Composite Rate and the ESRD PPS

(Rev.2905, Issued: 03-14-14, Effective: 10-01-14, Implementation: 10-01-14)

The electronic form required for billing ESRD claims is *the ASC X12 837 institutional claim transaction. The paper form, where permissable, is Form CMS-1450*.

The coding and related descriptions for the following items are identical for the ASC X12 837 institutional claim format and Form CMS-1450. See the related X12 implementation guide or Chapter 25, respectively, for where the information is reported.

Type of Bill

Acceptable codes for Medicare are:

721 - Admit Through Discharge Claim - This code is used for a bill encompassing an entire course of outpatient treatment for which the provider expects payment from the payer.

722 - Interim - First Claim - This code is used for the first of an expected series of payment bills for the same course of treatment.

723 - Interim - Continuing Claim - This code is used when a payment bill for the same course of treatment is submitted and further bills are expected to be submitted later.

724 - Interim - Last Claim - This code is used for a payment bill which is the last of a series for this course of treatment. The “Through” date of this bill (FL 6) is the discharge date for this course of treatment.

727 - Replacement of Prior Claim - This code is used when the provider wants to correct (other than late charges) a previously submitted bill. The previously submitted bill needs to be resubmitted in its entirety, changing only the items that need correction. This is the code used for the corrected or “new” bill.

728 - Void/Cancel of a Prior Claim - This code indicates this bill is a cancel-only adjustment of an incorrect bill previously submitted. Cancel-only adjustments should be used only in cases of incorrect provider identification numbers, incorrect HICNs, duplicate payments and some OIG recoveries. For incorrect provider numbers or HICNs, a corrected bill is also submitted using a code 721.

Statement Covers Period (From-Through) - Hospital-based and independent renal dialysis facilities:

The beginning and ending service dates of the period included on this bill. Note: ESRD services are subject to the monthly billing requirements for repetitive services.

Condition Codes

Hospital-based and independent renal facilities complete these items. Note that one of the codes 71-76 is applicable for every bill. Special Program Indicator codes A0-A9 are not required.

Condition Code Structure (only codes affecting Medicare payment/processing are shown).

02 - Condition is Employment Related - Providers enter this code if the patient alleges that the medical condition causing this episode of care is due to environment/events resulting from employment.

04 - Information Only Bill - Providers enter this code to indicate the patient is a member of a Medicare Advantage plan.

59 – Non-Primary ESRD Facility – Providers enter this code to indicate that ESRD beneficiary received non-scheduled or emergency dialysis services at a facility other than his/her primary ESRD dialysis facility.

71 - Full Care in Unit - Providers enter this code to indicate the billing is for a patient who received staff-assisted dialysis services in a hospital or renal dialysis facility.

72 - Self-Care in Unit - Providers enter this code to indicate the billing is for a patient who managed his own dialysis in a hospital or renal dialysis facility.

73 - Self-Care in Training - Providers enter this code to indicate the billing is for special dialysis services where a patient and his/her helper (if necessary) were learning to perform dialysis.

76 - Back-up In-facility Dialysis - Providers enter this code to indicate the billing is for a home dialysis patient who received back-up dialysis in a facility.

H3 – Reoccurrence of GI Bleed comorbid category

H4 – Reoccurrence of Pneumonia comorbid category

H5 – Reoccurrence of Pericarditis comorbid Category

Occurrence Codes and Dates

Codes(s) and associated date(s) defining specific events(s) relating to this billing period are shown. Event codes are two alpha-numeric digits, and dates are shown as six numeric digits (MM-DD-YY). When

occurrence codes 01-04 and 24 are entered, make sure the entry includes the appropriate value code, if there is another payer involved.

Occurrence and occurrence span codes are mutually exclusive. Occurrence codes have values from 01 through 69 and A0 through L9. Occurrence span codes have values from 70 through 99 and M0 through Z9.

24 - Date Insurance Denied - Code indicates the date of receipt of a denial of coverage by a higher priority payer.

33 - First Day of Medicare Coordination Period for ESRD Beneficiaries Covered by an EGHP - Code indicates the first day of the Medicare coordination period during which Medicare benefits are payable under an EGHP. This is required only for ESRD beneficiaries.

51 – Date of last Kt/V reading. For in-center hemodialysis patients, this is the date of the last reading taken during the billing period. For peritoneal dialysis patients and home hemodialysis patients, this date may be before the current billing period but should be within 4 months of the claim date of service.

Occurrence Span Code and Dates

Code(s) and associated beginning and ending dates(s) defining a specific event relating to this billing period are shown. Event codes are two alpha-numeric digits and dates are shown numerically as MM-DD-YY.

74 - Noncovered Level of Care - This code is used for repetitive Part B services to show a period of inpatient hospital care or of outpatient surgery during the billing period. Use of this code will not be necessary for ESRD claims with dates of service on or after April 1, 2007 due to the requirement of ESRD line item billing.

Document Control Number (DCN)

Required for all provider types on adjustment requests. (Bill Type/FL=XX7). All providers requesting an adjustment to a previous processed claim insert the DCN of the claims to be adjusted.

Value Codes and Amounts

Code(s) and related dollar amount(s) identify monetary data that are necessary for the processing of this claim. The codes are two alphanumeric digits and each value allows up to nine numeric digits (0000000.00). Negative amounts are not allowed. Whole numbers or non-dollar amounts are right justified to the left of the dollars and cents delimiter. Some values are reported as cents, so refer to specific codes for instructions. If more than one value code is shown for a billing period, show the codes in ascending alphanumeric sequence.

Value Code Structure (Only codes used to bill Medicare are shown.):

06 - Medicare Blood Deductible - Code indicates the amount the patient paid for un-replaced deductible blood.

13 - ESRD Beneficiary in the 30- Month Coordination Period With an EGHP - Code indicates that the amount shown is that portion of a higher priority EGHP payment on behalf of an ESRD beneficiary that applies to covered Medicare charges on this bill. If the provider enters six zeros (0000.00) in the amount field, it is claiming a conditional payment because the EGHP has denied coverage or there has been a substantial delay in its payment. Where the provider received no payment or a reduced payment because of failure to file a proper claim, this is the amount that would have been payable had it filed a proper claim.

17 – Not submitted by the provider. The Medicare shared system will display this payer only code on the claim when an outlier payment is being made. The value is the total claim outlier payment.

19 – Not submitted by the provider. The Medicare shared system will display this payer only code on the claim for low volume providers to identify the amount of the low volume adjustment being included in the provider's reimbursement.

37 - Pints of Blood Furnished - Code indicates the total number of pints of blood or units of packed red cells furnished, whether or not replaced. Blood is reported only in terms of complete pints rounded upwards, e.g., 1 1/4 pints is shown as 2 pints. This entry serves a basis for counting pints towards the blood deductible. Hospital-based and independent renal facilities must complete this item.

38 - Blood Deductible Pints - Code indicates the number of un-replaced deductible pints of blood supplied. If all deductible pints furnished have been replaced, no entry is made. Hospital-based and independent renal facilities must complete this item.

39 - Pints of Blood Replaced - Code indicates the total number of pints of blood donated on the patient's behalf. Where one pint is donated, one pint is replaced. If arrangements have been made for replacement, pints are shown as replaced. Where the provider charges only for the blood processing and administration, i.e., it does not charge a "replacement deposit fee" for un-replaced pints, the blood is considered replaced for purposes of this item. In such cases, all blood charges are shown under the 039x revenue code series, Blood Administration. Hospital-based and independent renal facilities must complete this item.

44 - Amount Provider Agreed To Accept From Primary Payer When This Amount is Less Than Charges But Higher than Payment Received - Code indicates the amount shown is the amount the provider was obligated or required to accept from a primary payer as payment in full when that amount is less than the charges but higher than amount actually received. A Medicare secondary payment is due.

47 - Any Liability Insurance - Code indicates amount shown is that portion from a higher priority liability insurance made on behalf of a Medicare beneficiary that the provider is applying to Medicare covered services on this bill. If six zeros (0000.00) are entered in the amount field, the provider is claiming conditional payment because there has been substantial delay in the other payer's payment.

48 - Hemoglobin Reading - Code indicates the most recent hemoglobin reading taken before the start of this billing period. This is usually reported in three positions with a decimal. Use the right of the delimiter for the third digit. The blood sample for the hemoglobin reading must be obtained before the dialysis treatment.

49 - Hematocrit Reading - Code indicates the most recent hematocrit reading taken before the start of this billing period. This is usually reported in two positions (a percentage) to the left of the dollar/cents delimiter. If the reading is provided with a decimal, use the position to the right of the delimiter for the third digit. The blood sample for the hemoglobin reading must be obtained before the dialysis treatment.

67 - Peritoneal Dialysis - The number of hours of peritoneal dialysis provided during the billing period. Count only the hours spent in the home. Exclude travel time. Report amount in whole units right-justified to the left of the dollar/cents delimiter. (Round to the nearest whole hour.)

Reporting value code 67 will not be required for claims with dates of service on or after April 1, 2007.

68 - Erythropoietin Units - Code indicates the number of units of administered EPO relating to the billing period and reported in whole units to the left of the dollar/cents delimiter. NOTE: The total amount of EPO injected during the billing period is reported. If there were 12 doses injected, the sum of the units administered for the 12 doses is reported as the value to the left of the dollar/cents delimiter.

Medicare no longer requires value code 68 for claims with dates of service on or after January 1, 2008.

71 - Funding of ESRD Networks - Code indicates the amount of Medicare payment reduction to help fund the ESRD networks. This amount is calculated by the FI and forwarded to CWF. (See §120 for discussion of ESRD networks).

79 – Not submitted by the provider. The Medicare shared system will display this payer only code on the claim. The value represents the dollar amount for Medicare allowed payments applicable for the calculation in determining an outlier payment.

A8 – Weight of Patient – Code indicates the weight of the patient in kilograms. The weight of the patient should be measured after the last dialysis session of the month.

A9 – Height of Patient – Code indicates the height of the patient in centimeters. The height of the patient should be measured during the last dialysis session of the month. This height is as the patient presents.

D5 – Result of last Kt/V reading. For in-center hemodialysis patients this is the last reading taken during the billing period. For peritoneal dialysis patients and home hemodialysis this may be before the current billing period but should be within 4 months of the claim date of service.

Revenue Codes

The revenue code for the appropriate treatment modality under the composite rate is billed (e.g., 0821 for hemodialysis). Services included in the composite rate and related charges must not be shown on the bill separately. Hospitals must maintain a log of these charges in their records for cost apportionment purposes.

Services which are provided but which are not included in the composite rate may be billed as described in sections that address those specific services.

082X - Hemodialysis - Outpatient or Home Dialysis - A waste removal process performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed directly from the blood. Detailed revenue coding is required. Therefore, services may not be summed at the zero level.

0 - General Classification	HEMO/OP OR HOME
1 – Hemodialysis/Composite or other rate	HEMO/COMPOSITE
2 - Home Supplies	HEMO/HOME/SUPPL
3 - Home Equipment	HEMO/HOME/EQUIP
4 - Maintenance 100%	HEMO/HOME/100%
5 - Support Services	HEMO/HOME/SUPSERV
9 - Other Hemodialysis Outpatient	HEMO/HOME/OTHER

083X - Peritoneal Dialysis - Outpatient or Home - A waste removal process performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed indirectly by instilling a special solution into the abdomen using the peritoneal membrane as a filter.

0 - General Classification	PERITONEAL/OP OR HOME
1 - Peritoneal/Composite or other rate	PERTNL/COMPOSITE
2 - Home Supplies	PERTNL/HOME/SUPPL
3 - Home Equipment	PERTNL/HOME/EQUIP
4 - Maintenance 100%	PERTNL/HOME/100%
5 - Support Services	PERTNL/HOME/SUPSERV
9 -Other Peritoneal Dialysis	PERTNL/HOME/OTHER

084X - Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient - A continuous dialysis process performed in an outpatient or home setting, which uses the patient's peritoneal membrane as a dialyzer.

0 - General Classification	CAPD/OP OR HOME
1 - CAPD/Composite or other rate	CAPD/COMPOSITE
2 - Home Supplies	CAPD/HOME/SUPPL
3 - Home Equipment	CAPD/HOME/EQUIP

4 - Maintenance 100%	CAPD/HOME/100%
5 - Support Services	CAPD/HOME/SUPSERV
9 -Other CAPD Dialysis	CAPD/HOME/OTHER

085X - Continuous Cycling Peritoneal Dialysis (CCPD) - Outpatient. - A continuous dialysis process performed in an outpatient or home setting, which uses the patient's peritoneal membrane as a dialyzer.

0 - General Classification	CCPD/OP OR HOME
1 - CCPD/Composite or other rate	CCPD/COMPOSITE
2 - Home Supplies	CCPD/HOME/SUPPL
3 - Home Equipment	CCPD/HOME/EQUIP
4 - Maintenance 100%	CCPD/HOME/100%
5 - Support Services	CCPD/HOME/SUPSERV
9 -Other CCPD Dialysis	CCPD/HOME/OTHER

088X - Miscellaneous Dialysis - Charges for Dialysis services not identified elsewhere.

0 - General Classification	DAILY/MISC
1 – Ultrafiltration	DAILY/ULTRAFILT
2 – Home dialysis aid visit	HOME DIALYSIS AID VISIT
9 -Other misc Dialysis	DAILY/MISC/OTHER

HCPCS/Rates

All hemodialysis claims must include HCPCS 90999 on the line reporting revenue code 082x.

Modifiers

Modifiers are required with ESRD Billing for reporting the adequacy of dialysis and the vascular access. For information on modifiers required for these quality measures see 50.9 of this chapter.

For information on reporting modifiers applicable to the Erythropoietin Stimulating Agents refer to section 60.4 of this chapter.

Route of administration modifiers required are JA, JB and JE.

For information on reporting the AY modifier for services not related to the treatment of ESRD, see sections 60.2.1.1 - Separately Billable ESRD Drugs and 60.1 - Lab Services.

Service Date

Report the line item date of service for each dialysis session and each separately payable item or service.

Service Units

Hospital-based and independent renal facilities must complete this item. The entries quantify services by revenue category, e.g., number of dialysis treatments. Units are defined as follows:

0634 - Erythropoietin (EPO) - Administrations, i.e., the number of times an injection of less than 10,000 units of EPO was administered. For claims with dates of service on or after January 1, 2008, facilities use the units field as a multiplier of the dosage description in the HCPCS to arrive at the dosage amount per administration.

0635 - Erythropoietin (EPO) - Administrations, i.e., the number of times an injection of 10,000 units or more of EPO was administered. For claims with dates of service on or after January 1, 2008, facilities use the

units field as a multiplier of the dosage description in the HCPCS to arrive at the dosage amount per administration.

082X - (Hemodialysis) - Sessions

083X - (Peritoneal) - Sessions

084X - (CAPD) - Days covered by the bill

085X - (CCPD) - Days covered by the bill

Effective April 1, 2007, the implementation of ESRD line item billing requires that each dialysis session be billed on a separate line. As a result, claims with dates of service on or after April 1, 2007 should not report units greater than 1 for each dialysis revenue code line billed on the claim.

Total Charges

Hospital-based and independent renal facilities must complete this item. Hospital-based facilities must show their customary charges that correspond to the appropriate revenue code. They must not enter their composite or the EPO` rate as their charge. Independent facilities may enter their composite and/or EPO rates.

Neither revenue codes nor charges for services included in the composite rate may be billed separately (see §90.3 for a description). Hospitals must maintain a log of these charges in their records for cost apportionment purposes.

Services which are provided but which are not included in the composite rate may be billed as described in sections that address those specific services.

The last revenue code entered in as 000l represents the total of all charges billed.

Principal Diagnosis Code

Hospital-based and independent renal facilities must complete this item and it should include a diagnosis of end stage renal disease.

Other Diagnosis Code(s)

For claims with dates of service on or after January 1, 2011 renal dialysis facilities report the appropriate diagnosis code(s) for co-morbidity conditions eligible for an adjustment.

50.6.2 - Payment for Hemodialysis Sessions

(Rev.2905, Issued: 03-14-14, Effective: 10-01-14, Implementation: 10-01-14)

Hemodialysis is typically furnished three times per week in sessions of three to five hours duration. Each hemodialysis session equals one composite rate payment. Therefore, three sessions per week is three composite rate payments. Dialysis furnished at this frequency ispaid without *the need for a secondary diagnosis to justify payment.* The justification must support the medical necessity of the service(s) being rendered.

50.7 - Ultrafiltration

(Rev.2905, Issued: 03-14-14, Effective: 10-01-14, Implementation: 10-01-14)

Ultrafiltration (revenue code 0881) is a process for removing excess fluid from the blood through the dialysis membrane by means of pressure. It is not a substitute for dialysis. Ultrafiltration is used in cases

where excess fluid cannot be removed easily during the regular course of hemodialysis. It is commonly done during the first hour or two of hemodialysis on patients who, for example, have refractory edema.

Pre-dialysis Ultrafiltration - While the need, if any, for pre-dialysis ultrafiltration varies from patient to patient, the facility's composite rate covers the full range of complicated and uncomplicated outpatient dialysis treatments. Therefore, no additional charge is recognized for pre-dialysis ultrafiltration.

Separate Ultrafiltration - Occasionally, medical complications require that ultrafiltration be performed at a time other than when a dialysis treatment is given, and in these cases an additional payment may be made. However, the *need for separate ultrafiltration* must be documented in the medical record and *a supporting other diagnosis must be included on the claim*. The FI determines the payment based on the facility's cost of furnishing the ultrafiltration, not to exceed the facility's composite rate.

60.1 - Lab Services

(Rev.2905, Issued: 03-14-14, Effective: 10-01-14, Implementation: 10-01-14)

See the Medicare Benefit Policy Manual, Chapter 11, for a description of lab services included in the composite rate.

Independent laboratories and independent dialysis facilities with the appropriate clinical laboratory certification in accordance with CLIA may be paid for ESRD clinical laboratory tests that are separately billable. The laboratories and independent dialysis facilities are paid for separately billable clinical laboratory tests according to the Medicare laboratory fee schedule for independent laboratories. (See Chapter 16, section 40.3 for details on Part B hospital billing rules for laboratory services and Chapter 16, section 40.6 for details on ESRD billing.)

Hospital-based laboratories providing separately billable laboratory services to dialysis patients of the hospital's dialysis facility or another dialysis facility bill and are paid in accordance with the hospital outpatient laboratory provisions in Chapter 16, section 40.3. If the ESRD patient also receives other hospital outpatient services on the same day as a specimen collection and/or laboratory test, then the patient is considered to be a registered hospital outpatient and cannot be considered to be a non-patient on that day for purposes of the specimen collection and laboratory test. When the patient does not also receive hospital outpatient services on the same day as the specimen collection and/or laboratory test, then the hospital may choose to register the beneficiary as an outpatient for the specimen collection or bill for these services as non-patient on the 14x bill type.

Clinical laboratory tests are performed individually. Automated profiles and application of the "50 percent rule" can be found in Chapter 16 of this manual.

A specimen collection fee determined by CMS (as of this writing, up to $3.00) will be allowed for ESRD Method II billing only in the following circumstances:

- Drawing a blood sample through venipuncture (i.e., inserting into a vein a needle with a syringe or vacutainer to draw the specimen).

- Collecting a urine sample by catheterization.

Laboratory tests for Hemodialysis, Intermittent Peritoneal Dialysis (IPD), Continuous Cycling Peritoneal Dialysis (CCPD), and Hemofiltration (as specified in the Medicare Benefit Policy Manual Pub. 100-02, Chapter 11, Section 30.2) are usually performed for dialysis patients and are routinely covered at the frequency specified in the absence of indications to the contrary, i.e., no documentation of medical necessity is required other than knowledge of the patient's status as an ESRD beneficiary. When any of these tests is performed at a frequency greater than that specified, the additional tests are separately billable and are

covered only if they are medically justified by accompanying documentation. A diagnosis of ESRD alone is not sufficient medical evidence to warrant coverage of the additional tests. The nature of the illness or injury (diagnosis, complaint, or symptom) requiring the performance of the test(s) must be present on the claim. Such information must be furnished using ICD *diagnosis codes*.

Effective January 1, 2011, section 153b of the MIPPA requires that all ESRD-related lab tests must be billed by the renal dialysis facility whether provided directly or under arrangements with an independent lab. When lab services are billed by providers other than the ESRD facility and the lab furnished is designated as a lab that is included in the ESRD PPS (ESRD-related), the claim will be rejected or denied. In the event that an ESRD-related lab service was furnished to an ESRD beneficiary for reasons other than for the treatment of ESRD, the provider may submit a claim for separate payment using modifier AY. ESRD facilities should only bill for labs related to the treatment of ESRD or non-ESRD related labs performed by the dialysis facility (i.e. CLIA waived lab tests). Lab tests that are not for the treatment of ESRD and not performed by the ESRD facility are not to be reported on the ESRD facility claim.

60.2.1.1 - Separately Billable ESRD Drugs

(Rev.2905, Issued: 03-14-14, Effective: 10-01-14, Implementation: 10-01-14)

The following categories of drugs (including but not limited to) are separately billable when used to treat the patient's renal condition:

- Antibiotics;
- Analgesics;
- Anabolics;
- Hematinics;
- Muscle relaxants;
- Sedatives;
- Tranquilizers; and
- Thrombolytics: used to declot central venous catheters. Note: Thrombolytics were removed from the separately billable drugs for claims with dates of service on or after January 1, 2013.

For claims with dates of service on or after July 1, 2013, when these drugs are administered through the dialysate the provider must append the modifier JE (Administered via Dialysate).

These separately billable drugs may only be billed by an ESRD facility if they are actually administered in the facility by the facility staff. Staff time used to administer separately billable drugs is covered under the composite rate and may not be billed separately. However, the supplies used to administer these drugs may be billed in addition to the composite rate.

Effective January 1, 2011, section 153b of the MIPPA requires that all ESRD-related drugs and biologicals be billed by the renal dialysis facility. When a drug or biological is billed by providers other than the ESRD facility and the drug or biological furnished is designated as a drug or biological that is included in the ESRD PPS (ESRD-related), the claim will be rejected or denied. In the event that an ESRD-related drug or biological was furnished to an ESRD beneficiary for reasons other than for the treatment of ESRD, the provider may submit a claim for separate payment using modifier AY.

All drugs reported on the renal dialysis facility claim are considered included in the ESRD PPS. The list of drugs and biologicals for consolidated billing are designated as always ESRD-related and therefore not allowing separate payment to be made to ESRD facilities. However, CMS has determined that some of these drugs may warrant separate payment.

Exceptions to "Always ESRD Related" Drugs:
The following drugs have been approved for separate payment consideration when billed with the AY modifier attesting to the drug not being used for the treatment of ESRD. The ESRD facility is required to indicate (in accordance with ICD *coding* guidelines) the diagnosis code for which the drug is indicated.

- Vancomycin, effective January 1, 2012
- Daptomycin, effective January 1, 2013

Items and services subject to the consolidated billing requirements for the ESRD PPS can be found on the CMS website at:
http://www.cms.gov/ESRDPayment/50_Consolidated_Billing.asp#TopOfPage.

Other drugs and biologicals may be considered separately payable to the dialysis facility if the drug was not for the treatment of ESRD. The facility must include the modifier AY to indicate it was not for the treatment of ESRD.

Drugs are assigned HCPCS codes. If no HCPCS code is listed for a drug (e.g., a new drug) the facility bills using HCPCS code J3490, "Unclassified Drugs," and submits documentation identifying the drug. To establish a code for the drug, the FI checks HCPCS to verify that there is no acceptable HCPCS code for billing and if a code is not found checks with the local carrier, which may have a code and price that is appropriate. If no code is found the drug is processed under HCPCS code J3490. See Chapter 17 for a complete description of drug pricing.

60.2.4.2 - Physician Billing Requirements to the Carrier

(Rev.2905, Issued: 03-14-14, Effective: 10-01-14, Implementation: 10-01-14)

A. Sodium Ferric Gluconate Complex in Sucrose Injection

Sodium Ferric Gluconate Complex in sucrose injection may be payable for claims with dates of service on or after December 1, 2000 when furnished intravenously, for first line treatment of iron deficiency anemia in patients undergoing chronic hemodialysis who are receiving supplemental erythropoeitin therapy. Physicians bill and carriers pay for HCPCS code J1756 when submitted with a primary diagnosis for chronic renal failure and a secondary diagnosis for iron deficiency anemia.

These are:

Chronic Renal Failure (Primary Diagnosis)

- *ICD-9-CM – 585*
- *ICD-10-CM –N18.3, N18.4, N18.5, N18.6,*

Iron Deficiency Anemia (Secondary Diagnosis)

- *ICD-9-CM – 280.0, 280.1, 280.8, or 280.9*
- *ICD-10-CM – D50.0, D50.1, D50.8, D50.9,D63.1*

This benefit is subject to the Part B deductible and coinsurance and should be paid per current Medicare drug payment reimbursement rules. Carriers may cover other uses of this drug at their discretion.

B. Iron Sucrose Injection

Iron Sucrose injections are payable for claims with dates of service on or after October 1, 2001, when furnished intravenously, for first line treatment of iron deficiency anemia in patients undergoing chronic hemodialysis who are receiving supplemental erythropoeitin therapy. Until a specific code for iron sucrose injection is developed, providers must submit HCPCS code *J1756*, with the appropriate explanation of drug name and dosage entered *on the claim*. The primary diagnosis code for chronic renal failure and one of the following secondary diagnosis codes for iron deficiency must be entered.

These are:

Chronic Renal Failure (Primary Diagnosis)

- *ICD-9-CM - 585*
- *ICD-10-CM - N18.3, N18.4, N18.5, N18.6,*

Iron Deficiency Anemia (Secondary Diagnosis)

- *ICD-9-CM – 280.0, 280.1, 280.8, or 280.9*
- *ICD-10-CM – D50.0, D50.1, D50.8, D50.9,D63.1*

Iron sucrose injection is subject to the Part B deductible and coinsurance and should be paid per current Medicare drug payment reimbursement rules. Carriers may cover other uses of this drug at their discretion.

C. Messages for Use with Denials

The following denial messages should be used to deny claims for sodium ferric gluconate complex in sucrose injection or iron sucrose injection due to a missing diagnosis code.

Remittance Advice: Claim adjustment reason code 16, Claim/service lacks information which is needed for adjudication, along with remark code M76, Incomplete/invalid patient's diagnosis(es) and condition (s).

Explanation of Medicare Benefits: 9.8, Medicare cannot pay for this service because the claim is missing information/documentation.

Medicare Summary Notice: 9.2, This item or service was denied because information required to make payment was missing.

60.4.2.1 - Other Information Required on the Form CMS-1500 for Epoetin Alfa (EPO)

(Rev.2905, Issued: 03-14-14, Effective: 10-01-14, Implementation: 10-01-14)

The following information is required for EPO. Incomplete assigned claims are returned to providers for completion. Incomplete unassigned claims are rejected. The rejection will be due to a lack of a HCT value. Note that when a claim is submitted on paper Form CMS-1500, these items are submitted on a separate document. It is not necessary to enter them into the claims processing system. This information is used in utilization review.

A. Diagnoses - The diagnoses must be submitted according to *ICD coding guidelines* and correlated to the procedure. This information is in Item 21, of the Form CMS-1500.

B. Hematocrit (HCT)/Hemoglobin (Hgb) - There are special HCPCS codes for reporting the injection of EPO for claims with dates of service prior to January 1, 2004. These allow the simultaneous reporting of the patient's latest HCT or Hgb reading before administration of EPO.

The physician and/or staff are instructed to enter a separate line item for injections of EPO at different HCT/Hgb levels. The Q code for each line items is entered in Item 24D.

1. Code Q9920 - Injection of EPO, per 1,000 units, at patient HCT of 20 or less/Hgb of 6.8 or less.

2. Codes Q9921 through Q9939 - Injection of EPO, per 1,000 units, at patient HCT of 21 to 39/Hgb of 6.9 to 13.1. For HCT levels of 21 or more, up to a HCT of 39/Hgb of 6.9 to 13.1, a Q code that includes the actual HCT levels is used. To convert actual Hgb to corresponding HCT values for Q code reporting, multiply the Hgb value by 3 and round to the nearest whole number. Use the whole number to determine the appropriate Q code.

EXAMPLES: If the patient's HCT is 25/Hgb is 8.2-8.4, Q9925 must be entered on the claim. If the patient's HCT is 39/Hgb is 12.9-13.1, Q9939 is entered.

3. Code Q9940 - Injection of EPO, per 1,000 units at patient HCT of 40 or above.

A single line item may include multiple doses of EPO administered while the patient's HCT level remained the same.

Codes Q9920-Q9940 will no longer be recognized by the system if submitted after March 31, 2004. If claims for dates of service prior to January 1, 2004 are submitted after March 31, 2004, then code Q4055 must be used.

C. Units Administered - The standard unit of EPO is 1,000. The number of 1,000 units administered per line item is included on the claim. The physician's office enters 1 in the units field for each multiple of 1,000 units. For example, if 12,000 units are administered, 12 is entered. This information is shown in Item 24G (Days/Units) on Form CMS-1500.

In some cases, the dosage for a single line item does not total an even multiple of 1,000. If this occurs, the physician's office rounds down supplemental dosages of 0 to 499 units to the prior 1,000 units. Supplemental dosages of 500 to 999 are rounded up to the next 1,000 units.

EXAMPLES:

A patient's HCT reading on August 6 was 22/Hgb was 7.3. The patient received 5,000 units of EPO on August 7, August 9, and August 11, for a total of 15,000 units. The first line of Item 24 of Form CMS-1500 shows:

Dates of Service	Procedure Code	Days or Units
8/7 - 8/11	Q9922	15

On September 13, the patient's HCT reading increased to 27/Hgb increased to 9. The patient received 5,100 units of EPO on September 13, September 15, and September 17, for a total of 15,300 units. Since less than 15,500 units were given, the figure is rounded down to 15,000. This line on the claim form shows:

Dates of Service	Procedure Code	Days or Units
9/13 - 9/17	Q9927	15

On October 16, the HCT level increased to 33/Hgb increased to 11. The patient received doses of 4,850 units on October 16, October 18, and October 20 for a total of 14,550 units. Since more than 14,500 units were administered, the figure is rounded up to 15,000. Form CMS-1500 shows:

Dates of Service	Procedure Code	Days or Units
10/16 - 10/20	Q9933	15

NOTE: Creatinine and weight identified below are required on EPO claims as applicable.

D. Date of the Patient's most recent HCT or Hgb.

E. Most recent HCT or Hgb level - (prior to initiation of EPO therapy).

F. Date of most recent HCT or Hgb level - (prior to initiation of EPO therapy).

G. Patient's most recent serum creatinine - (within the last month, prior to initiation of EPO therapy).

H. Date of most recent serum creatinine - (prior to initiation of EPO therapy).

I. Patient's weight in kilograms

J. Patient's starting **dose per kilogram** - (The usual starting dose is 50-100 units per kilogram.)

60.4.6.1 - Other Information Required on the Form CMS - 1500 for Darbepoetin Alfa (Aranesp)

(Rev.2905, Issued: 03-14-14, Effective: 10-01-14, Implementation: 10-01-14)

Note: Effective January 1, 2011 Method II and Supplier billing for ESRD related items and services is no longer applicable. The Medicare Improvements for Patients and Providers Act (MIPPA) section 153b requires that all payments related to the treatment of ESRD be paid to the ESRD facility treating the patient.

The following information is required for Aranesp. Incomplete assigned claims are returned to providers for completion. Incomplete unassigned claims are rejected. The rejection will be due to a lack of a HCT value. Note that when a claim is submitted on paper Form CMS-1500, these items are submitted on a separate document. It is not necessary to enter them into the claims processing system. This information is used in utilization review.

A. Diagnoses - The diagnoses *codes* must be submitted and must be correlated to the procedure. *ICD-9-CM is used for service provided before October 1, 2014. ICD-10-CM is used for services provided October 1, 2014 or later.*

B. Date of the Patient's most recent HCT.

C. Most recent HCT (prior to initiation of Aranesp therapy).

D. Date of most recent HCT (prior to initiation of Aranesp therapy).

F. Patient's most recent serum creatinine - (within the last month, prior to initiation of Aranesp therapy).

G. Date of most recent serum creatinine - (prior to initiation of Aranesp therapy).

H. Patient's weight in kilograms

I. Patient's starting dose per kilogram

80.2 - General Intermediary Bill Processing Procedures for Method I Home Dialysis Services

(Rev.2905, Issued: 03-14-14, Effective: 10-01-14, Implementation: 10-01-14)

General instructions for completing the *Form CMS-1450* are in Chapter 25. *Instructions for completing the ASC X12 837institutional format are in the related training guide, available on the Washington Publishing Company's web site at http://www.wpc-edi.com/* Instructions in §§50 and 50.3, above, apply to provider reporting of ESRD home dialysis services under Method I.

All home dialysis patients must have chosen either Method I or Method II.

The FI uses the method of election information provided in the "Method" field of CWF trailer 14 "ESRD Method Trailer" attached to the query response when an ESRD claim is submitted for approval.

If the beneficiary has elected Method I, the FI pays the facility the composite rate plus any additional billable services.

If the beneficiary has elected Method II, the facility is not paid the composite rate or for home dialysis supplies and equipment. Payment is made only for support, backup, and emergency dialysis services.

100.3 - Physician's Services Furnished to a Dialysis Patient Away From Home or Usual Facility

(Rev.2905, Issued: 03-14-14, Effective: 10-01-14, Implementation: 10-01-14)

When a dialysis patient whose attending physician receives a monthly payment receives maintenance dialysis services of any kind outside the usual setting from any physician who is neither the attending physician nor that physician's substitute, the following procedures apply:

- The physician who furnished the service submits a claim to the local carrier of jurisdiction;
- The carrier will process the claim and send an MSN to the patient;
- The carrier that has jurisdiction over the usual dialysis setting adjusts the MCP to the usual attending physician to account for the time the patient was absent from the usual dialysis setting.
- The carrier that has jurisdiction over the usual dialysis setting adjusts the MCP to the usual attending physician per §140.3.E below to account for the time the patient was absent from the usual dialysis setting.

Carriers must notify physicians that claims for services furnished to temporary patients must be identified as a claim for a temporary patient. The physician must indicate "temporary patient" *on the claim*.

130 - Physicians and Supplier (Nonfacility) Billing for ESRD Services - General

(Rev.2905, Issued: 03-14-14, Effective: 10-01-14, Implementation: 10-01-14)

Payment for renal-related physicians' services to ESRD patients is made in either of the following ways:

- Under the Monthly Capitation Payment (MCP) (see §140 below for an explanation of the MCP); or

- Using the daily codes for ESRD services (CPT codes 90922-90925) with units that represent the number of days services were furnished.

- Under the Initial method (IM)
    - The carrier receives bills from physicians for services furnished ESRD beneficiaries.
    - Intermediaries receive bills from ESRD facilities.
    - Lab bills from CLIA certified independent dialysis facilities were billed to the carrier before September 1, 1997, and to the FI beginning on that date. Other certified labs bill the carrier.

140.3 - Data Elements Required on Claim for Monthly Capitation Payment

(Rev.2905, Issued: 03-14-14, Effective: 10-01-14, Implementation: 10-01-14)

On Form CMS-1500

A. Elements 1 through 13 of the Form CMS-1500 are completed in accordance with the regular instructions

B. Elements 14 through 20 of the Form CMS-1500 are omitted.

C. Element 21 must contain the name and address of the facility involved with the patient's maintenance care or training.

D. Element 23A must show the diagnosis, and whether the patient is in training for self-dialysis. Element 23B is left blank.

E. Element 24A must show the dates of service during the month that are included in the MCP. The period includes the full calendar month the MCP physician or practitioner was responsible for the beneficiary's ESRD related care.

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

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

F. Element 24C must show the initials "MCP" as the indicator needed to identify the claim as a request for the MCP.

G. The remainder of the Form CMS-1500 is completed in accordance with the general instructions.

On ASC X12 Professional Format

See the ASC X12 837 professional training guide.