CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3311	**Date: August 6, 2015**
	Change Request 9265

SUBJECT: End Stage Renal Disease (ESRD) Home Dialysis Policy

I. SUMMARY OF CHANGES: In the CY 2015 Physician Fee Schedule (PFS) final rule (79 FR 67733) we finalized a change to home dialysis (less than a full month) to provide consistency with our policy for partial month scenarios pertaining to patients dialyzing in a dialysis center.

EFFECTIVE DATE: January 1, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: September 8, 2015

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	8/140.2.1/Guidelines for Physician or Practitioner Billing -- (Per Diem)

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 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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3311	Date: August 6, 2015	Change Request: 9265

SUBJECT: End Stage Renal Disease (ESRD) Home Dialysis Policy

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I. GENERAL INFORMATION

A. Background: In the Calendar Year (CY) 2005 Physician Fee Schedule (PFS) final rule with comment period (69 FR 66357 through 66359), we established criteria for furnishing outpatient per diem ESRD-related services in partial month scenarios. We specified that use of per diem ESRD-related services is intended to accommodate unusual circumstances when the outpatient ESRD-related services would not be paid for under the monthly capitation payment (MCP), and that use of the per diem services are limited to the circumstances listed below.

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

Additionally, we provided billing guidelines for partial month scenarios in the Medicare claims processing manual, publication 100-04, chapter 8, section 140.2.1. For center-based patients, we specified that if the MCP practitioner furnishes a complete assessment of the ESRD beneficiary, the MCP practitioner should bill for the full MCP service that reflects the number of visits furnished during the month. However, we did not extend this policy to home dialysis (less than a full month) because the home dialysis MCP service did not include a specific frequency of required patient visits. In other words, unlike the ESRD MCP service for center-based patients, a visit was not required for the home dialysis MCP service as a condition of payment.

In the CY 2011 PFS final rule with comment period (75 FR 73295 through 73296), we changed our policy for the home dialysis MCP service to require the MCP practitioner to furnish at least one face-to-face patient visit per month as a condition of payment. However, we inadvertently did not modify our billing guidelines for home dialysis (less than a full month) to be consistent with partial month scenarios for center-based dialysis patients and stakeholders brought this inconsistency to our attention as part of the CY 2015 PFS rulemaking cycle.

As discussed in the CY 2015 PFS final rule (79 FR 67733), we finalized a change to home dialysis (less than a full month) to provide consistency with our policy for partial month scenarios pertaining to patients dialyzing in a dialysis center.

B. Policy: The MCP physician or practitioner should bill for the age appropriate home dialysis MCP service (as described by HCPCS codes 90963 through 90966) for the home dialysis (less than a full month) scenario if the MCP practitioner furnishes a complete monthly assessment of the ESRD beneficiary and at least one face-to-face patient visit during the month. For example, if a home dialysis patient was hospitalized during the month and at least one face-to-face outpatient visit and complete monthly assessment was

furnished, the MCP practitioner should bill for the full home dialysis MCP service.

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	
9265.1	Consistent with current policy for partial month scenarios for center based ESRD beneficiaries, Medicare claims processing contractors shall pay the MCP practitioner for the full ESRD MCP service code if the MCP practitioner furnishes a complete monthly assessment of the ESRD beneficiary and at least one face-to-face patient visit during the month.		X							
9265.2	Contractors need not search history for previously processed claims, but shall adjust any claims brought to their attention.		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9265.3	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/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 sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's 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			

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): Kathleen Kersell, 410-786-2033 or kathleen.kersell@cms.hhs.gov (Payment policy contact)

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.

ATTACHMENTS: 0

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

(Rev.3311, Issued: 08-06-15, Effective: 01-01-15, Implementation: 09-08-15)

A. Home dialysis, transient patient and partial month

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

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

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

For home dialysis patients (less than full month) if the MCP physician or practitioner furnishes a complete monthly assessment of the ESRD beneficiary and at least one face-to-face patient visit during the month, he or she should bill for the age appropriate home dialysis MCP service. For example, if a home dialysis patient was hospitalized during the month and at least one face-to-face outpatient visit and complete monthly assessment was furnished, the MCP physician or practitioner should bill for the full home dialysis MCP service.

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

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

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

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

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

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

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

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

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

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

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