Related MLN Matters Article #: MM5039 Revised

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Line Item Billing Requirement for End Stage Renal Disease (ESRD) Claims

Key Words

MM5039, CR5039, R1084CP, ESRD, Renal, Line Billing

Provider Types Affected

Providers billing Medicare Fiscal Intermediaries (FIs) for ESRD services

Note: MLN Matters article MM5039 was revised on January 22, 2008, to add references to related Change Requests (CR) 5768 and 5545. These additional references may be found in the Important Links section below.

Key Points

- The effective date of the instruction is April 1, 2007.
- The implementation date is April 2, 2007.
- CR5039 provides updates to line item billing requirements for ESRD claims (Type of Bill 72X).
- CR5039 instructs that line item billing is required for all ESRD claims with dates of service on or after April 1, 2007.
- Renal dialysis facilities are then required to bill all services with line item date of service detail, except supplies and Epoetin alfa.
- In compliance with the Health Insurance Portability and Accountability Act (HIPAA) Implementation Guide, the Centers for Medicare & Medicaid Services (CMS) **requires that all outpatient claims contain a line item date of service for each revenue code billed on the claim.**
- CMS has completed implementation of line item billing for most institutional Part B claims and has encouraged renal dialysis facilities (RDFs) to begin line item billing.
- CMS has permitted RDFs to continue to roll-up the services provided through-out the month and choose one date of service within the billing period on the claim to report all instances of each revenue code on a single line.

- As a result, ESRD claims are currently being received and processed using both methods:
  - Line item billing and
  - Services rolled-up for all instances of each revenue code.
- The method of rolling up all instances of each revenue code on a single line does not provide the most accurate claims data, since the claim is reporting that all of a given service is provided on the same date. Inherent with this method of billing is an increase in the number of claims that cannot be processed to payment due to claims with overlapping dates of service.
- In these overlapping claim cases, RDFs must report service dates of other providers within the month they are billing using an occurrence span code 74 on the claim to prevent the overlap of the claims and allow both claims to be paid. RDFs have expressed to CMS that this is a difficult task because they are not always informed of the beneficiary receiving services performed by other providers.
- The Medicare claims processing system has the ability to compare services on multiple claims to the line date that could prevent both the unnecessary suspension of claims for overlapping billing periods and the reporting of the occurrence span code 74 for the RDFs.
- To apply this system functionality to the ESRD claims, the claim must provide the line item date of service detail for each service being billed on the claim. This is a substantial benefit that line item billing can provide for RDFs in submitting ESRD claims.

Benefits of Line Item Billing

- The benefits of line item billing include:
  - More accurate and timely claim payments to providers;
  - Less staff time needed to research dates of services performed by other providers;
  - Clinical data will no longer need to be rolled up to accommodate the claims processing systems and therefore, will more closely match the claim record;
  - More detailed claim data could be used to assist the CMS in future refinements to improve the accuracy and equity of ESRD payments; and
  - HIPAA compliance for submitting the appropriate line item date of service for both the CMS and its providers is ensured.

Line Item Details

- CR5039 instructions to RDFs include the following:
  - RDFs should bill a separate line item for each dialysis session performed.
  - RDFs should report the appropriate line item date of service to conform with the date the service was provided to the beneficiary. The units reported on the line for each date dialysis was performed should not exceed one.
  - The use of occurrence span code 74 will not be necessary for ESRD claims with dates of service on or after April 1, 2007.
  - Reporting value code 67 will not be required for ESRD claims with dates of service on or after April 1, 2007.

- Medicare FIs will return to the provider any claims with dates of service on or after April 1, 2007, when the claim contains units exceeding 1 reported on lines containing revenue codes 0821, 0831, 0841, or 0851.

Coding Adequacy for Hemodialysis

- All claims billing for hemodialysis sessions must continue to report:
  - Healthcare Common Procedure Coding System (HCPCS) code 90999 (unlisted dialysis procedure, inpatient or outpatient), and
  - Modifiers G1 through G6 used for reporting the urea reduction ratio for determining the adequacy of hemodialysis.
- It is not required that HCPCS code 90999 and a G1 through G6 modifier be reported on every line item that contains a hemodialysis session.

Home Dialysis Under Method One

- For intermittent home dialysis under method one, providers should submit a separate line item for each dialysis session using the dates in the pre-determined plan of care schedule provided to the beneficiary unless informed by the beneficiary that the schedule was changed.
- In the event that the schedule was changed, the provider should note the changes in the medical record and bill according to the revised schedule.
- For Continuous Ambulatory Peritoneal Dialysis and Continuous Cycling Peritoneal Dialysis under method one, providers should submit a separate line item for the dialysis for each day of the month.
- If the provider is aware of an inpatient stay for the beneficiary within the month, the RDF may include the date of admission and date of discharge as a billable day for the dialysis but should omit the dates within the inpatient stay.
- In the event that the RDF is unaware of an inpatient stay during the month, the Medicare system will detect the overlapping dates and reject only the line item dates within the inpatient stay but pay the remainder of the claim for any dates that are not within the inpatient stay.

Important Links

The related MLN Matters article can be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5039.pdf* on the CMS website.

The official instruction (CR5039) issued regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1084CP.pdf* on the CMS website.

Providers may also want to review CR5768 (*http://www.cms.hhs.gov/Transmittals/downloads/R1364CP.pdf*) and CR5545 (*http://www.cms.hhs.gov/Transmittals/downloads/R1285CP.pdf*). These CRs added to the requirements initiated in CR5039.

The related MLN Matters articles may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5768.pdf* and *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5545.pdf* on the CMS website.

If providers have any questions, they may contact their intermediary at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.