Medicare
Carriers Manual
Part 3 - Claims Process

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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CHANGE REQUEST 1799

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
4270.1 – 4272.3	4-67 – 4-68.1 (9 pp.)	4-67 – 4-68.2 (9 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: July 1, 2002*
IMPLEMENTATION DATE: July 1, 2002

Section 4270, ESRD Bill Processing Procedures, is being updated to specify that Method II suppliers must bill with a "ZX" modifier when submitting claims for Method II ESRD beneficiaries. The revision also provides further guidance regarding support service facilities.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

NOTE: Forms CMS-382, CMS-1490S, and CMS-1500 are currently available only as HCFA forms. The new CMS forms will be issued as the stock of the older versions is depleted.

o If the HMO splits the bill, process that portion of the claim designated by the HMO.

o If the claim is for out-of-plan services (see §9050.C) and the HMO is reimbursed on a cost basis (R-trailer codes l or 2), process the claim.

4270. ESRD BILL PROCESSING PROCEDURES

Physicians, independent laboratories, and beneficiaries must submit claims (Form CMS-1500, Form CMS-1490S or electronic equivalent) to their local carrier for services furnished to end stage renal disease (ESRD) beneficiaries. Suppliers of Method II dialysis equipment and supplies will submit their claims (Form CMS-1500 or electronic equivalent) to the appropriate Durable Medical Equipment Regional Carriers (DMERCs). All ESRD facilities must submit their claims to their appropriate fiscal intermediary (FI).

4270.1 Home Dialysis Supplies and Equipment.--Only a supplier that is not a dialysis facility may submit a claim to a DMERC for home dialysis supplies and equipment. Suppliers will submit these claims on Form CMS 1500, or electronic equivalent. Under Method II, beneficiaries may not submit any claims and cannot receive payment for any benefits for home dialysis equipment and supplies. DMERCs must deny unassigned and beneficiary submitted claims.

Use the following messages for beneficiary submitted or unassigned claims.

MSN # 16.6: "This item or service cannot be paid unless the provider accepts assignment.

Spanish: "Este article servicio no se pagará a menos de que el proveedor acepte asignación."

MSN # 16.7: "Your provider must complete and submit your claim."

Spanish: "Su proveedor debe completar y someter su reclamación."

MSN# 16.36: "If you have already paid it, you are entitled to a refund from this provider."

Spanish: "Si usted ya lo ha pagado, tiene derecho a un reebolso de su proveedor."

In accordance with the Code of Federal Regulations (CFR), Method II patients who self-administer erythropoietin (EPO) may only obtain EPO from either their Method II supplier, or a Medicare certified ESRD facility. (See 42 CFR 414.335)

For purposes of home dialysis, a skilled nursing facility (SNF) may qualify as a beneficiary's home.

A. Requirements for Payment.—DMERCS may make payment to home dialysis suppliers only if all of the following conditions are met:

o The beneficiary has elected Method II (see §4271);

o The supplier accepts assignment for all Method II equipment and supplies;

o The supplier agrees to be the beneficiary's sole supplier for all home dialysis equipment and supplies;

o The supplier agrees to bill on a monthly basis for the quantity of supplies used during that period. (However, there is one exception to this rule. Beneficiaries are permitted to retain 1 month's worth of supplies in reserve in case of emergency);

o The supplier maintains a written certification in its files that it has a written agreement with a Medicare approved dialysis facility under which the facility will furnish all

necessary support, backup, and emergency dialysis services, for each beneficiary the supplier services. (For Medicare beneficiaries who are also entitled to military or veterans benefits, a military or Veteran's Administration (VA) hospital satisfies this requirement.) The supplier may not provide supplies or services to the beneficiary, or submit a claim to the DMERC, until they have a valid written support service facility agreement for that beneficiary. The dialysis facility must be a reasonable distance from the beneficiary's home in order to furnish these services. Determine a reasonable distance by considering such variables as terrain, whether the patient's home is located in a rural or urban area, and the usual distances traveled and time in transit by patients in the area in obtaining health care services.

In cases where a supplier cannot establish an agreement with a support service facility that is within a reasonable distance from the patient's home, the supplier must establish a written agreement with a support service facility outside of the geographic area of the patient's home. However, in this situation, the support service facility must establish a written agreement with a dialysis facility within the beneficiary's geographic region to provide any required in-facility dialysis treatments. In this situation, the support service facility will be responsible for providing all other necessary services for the patient, and must provide for the coordination of the patient's care and monitor the patient through frequent visits to the patient's home. The signed agreement with the Method II supplier must stipulate how the support services facility will provide each of the required support services. The written agreement must include documentation to support the arrangement with the local facility for any needed in-facility services.

Home dialysis support services include, but are not limited to:

- Surveillance of the patient's home adaptation, including provisions for visits to the home in accordance with a written plan prepared and periodically reviewed by a team that includes the patient's physician and other professionals familiar with the patient's condition;
- Furnishing dialysis-related emergency services;
- Consultation for the patient with a qualified social worker and a qualified dietician;
- Maintaining a recordkeeping system which assures continuity of care;
- Maintaining and submitting all required documentation to the ESRD network;
- Assuring that the water supply is of the appropriate quality;
- Assuring that the appropriate supplies are ordered on an ongoing basis;
- Arranging for the provision of all ESRD related laboratory tests;
- Testing and appropriate treatment of water used in dialysis;
- Monitoring the functioning of dialysis equipment;
- All other necessary dialysis services as required under the ESRD conditions for coverage; and
- Since home dialysis support services include maintaining a medical record for each home dialysis patient, the Method II supplier must report to the support service dialysis facility within 30 days all items and services that it furnished to the patient so that the facility can record this information in the patient's medical record.

Method II suppliers must maintain documentation to support the existence of a written agreement with a Medicare certified support service facility within a reasonable distance from the beneficiary's home. Effective July 1, 2002, suppliers must use the "ZX" modifier on the line item level for all

Method II home dialysis claims to indicate that they have this documentation on file, and must provide it to the DMERC upon request. As of July 1, 2002, DMERCs must front end reject any Method II claims that do not have the "ZX" modifier at the line item level. The supplier may correct and resubmit the claim with the appropriate modifier. DMERCs and the standard systems must make all systems changes necessary to reject Method II claims that do not have the "ZX" modifier. DMERCs must publish this new requirement on their websites and in their next regularly scheduled supplier bulletins.

B. Amount of Payment.--The allowance per month under Method II for home dialysis equipment and supplies may not exceed $1,490.85 per month for all forms of dialysis except continuous cycling peritoneal dialysis (CCPD). For CCPD, the allowance may not exceed $1,974.45 per month. The actual amount paid is based on this limit or any lower limit that you have set (e.g., by applying the usual reasonable charge rules or the inherent reasonableness instructions in §5246.7) less the Part B coinsurance and any unmet Part B deductible amounts.

C. Sample Letter to Method II Supplier.--DMERCs must explain the Medicare requirements to every Method II supplier that they service. Below is a sample letter for DMERC use.

Dear Method II Supplier:

Our records show that you supply home dialysis equipment and/or supplies to Medicare home dialysis beneficiaries who have chosen payment Method II. The Medicare law was recently changed for Method II. Effective February 1, 1990, there will be a limit on the amount that a dialysis supplier may be paid under Method II.

The payment limit for Method II benefits for all forms of dialysis except CCPD cannot exceed the median composite rate for hospital-based dialysis facilities. The portion of this amount that applies to supplies and equipment is $1,490.85 per month. The limit for CCPD supplies and equipment is based on 130 percent of the composite rate and is $1,974.45 per month. These limits are subject to the usual Medicare Part B deductible and coinsurance amounts.

There are additional requirements for Method II benefits. Each Method II beneficiary must certify in writing that he or she deals with a single supplier for all home dialysis equipment and supplies. Beneficiaries who have chosen Method II before February 1, 1990, are presumed to meet this requirement and need not submit this certification. If a beneficiary chooses Method II on or after February 1, 1990, the beneficiary (or the dialysis facility or the supplier on the beneficiary's behalf) writes the following in Block 8 of Form CMS-382:

"I certify that I have only one Method II supplier."

As a Method II home dialysis supplier, in order to be paid Medicare benefits, you must:

o Be the beneficiary's sole supplier for all home dialysis equipment and supplies needed by the beneficiary;

o Accept assignment of Medicare benefits for all home dialysis equipment and supplies you supply to Medicare beneficiaries. If you do not accept assignment, inform your Medicare beneficiaries that you do not accept assignment and that, therefore, Medicare CANNOT pay for his/her home dialysis equipment or supplies;

o Maintain written certifications in your files that you have a written agreement with a Medicare approved dialysis facility under which the facility will furnish all necessary support, backup, and emergency dialysis services for each beneficiary you serve. Support services include, but are not limited to, maintaining the patient's medical record and providing information required by the ESRD network. For each of your Medicare beneficiaries, you must have this agreement with a dialysis facility that is a reasonable distance from the beneficiary's home. CMS determines a reasonable distance by considering such variables as terrain, whether the beneficiary's home is in

an urban or rural area, and the usual distances traveled and time in transit by patients in the area when obtaining health services. In cases where you cannot establish an agreement with a support service facility that is within a reasonable distance from the patient's home, you must establish a written agreement with a support service facility outside of the geographic area of the patient's home. In this situation, the support service facility must establish a written arrangement with a dialysis facility within the beneficiary's geographic region to provide any required in-facility dialysis treatments. In this situation, the support service facility will be responsible for providing all other necessary services for the beneficiary and must provide for the coordination of the patient's care and monitor the patient through frequent visits to the patient's home. The signed agreement with the Method II supplier must stipulate how the support services facility will provide each of the required support services. The written agreement must include documentation to support the arrangement with the local facility for any needed in-facility services. You may not provide services or submit a claim to Medicare before you obtain this agreement. You need not identify individual beneficiaries.

o Report to the support service dialysis facility within 30 days all items and services that you furnish to the patient so that his information can be recorded by the facility in the medical record; and

o Agree to generally bill once a month and for only 1 month's quantity of supplies at a time. In the event that a beneficiary becomes a hospital inpatient for at least 3 days (not counting the day of admission or discharge), you must prorate the following month's supply bills to account for supplies the beneficiary did not use while an inpatient.

4270.2 Bill Review of Laboratory Services.--See §5114.1 for a detailed description of payment for outpatient clinical diagnostic laboratory tests using fee schedules and for specimen collection fees.

All laboratory tests not included under the ESRD composite rate payment and performed by an independent laboratory for dialysis patients of independent dialysis facilities must be billed by the independent laboratory to carriers. The fee schedule applies to all clinical diagnostic tests except for tests already included under the ESRD composite rate payment. These tests are reimbursed only through the composite rate paid by the intermediary.

Laboratory tests not included under the ESRD composite rate payment, including all laboratory tests furnished to home dialysis patients who have selected payment Method II (see §427l), are billed to and paid by you at the fee schedule, if the tests are performed by an independent laboratory for an independent dialysis facility patient.

For purposes of the fee schedule, clinical diagnostic laboratory services include all laboratory tests listed in codes 80002-89399 of the Current Procedural Terminology Fourth Edition (CPT-4) with the following exceptions:

85095-85109	Codes dealing with bone marrow smears and biopsies
85120	Bone marrow transplant
88000-88130	Certain cytopathology services
88160-88199	Certain cytopathology services
88260-88299	Cytogenetic studies
88300-88399	Surgical pathology services

Services excluded from the fee schedule when billed by an independent laboratory are payable under existing reasonable charge rules.

Where tests not included in the composite rate are performed, the lab includes all tests (both those included in the composite rate and those that meet the frequency guidelines) on the bill. The tests listed below are included in the composite rate if their frequency does not exceed that which is indicated. Do not pay for tests up to the frequency described as they are paid under the composite rate. Tests in excess of the frequency may be paid unless you determine they are not medically necessary. Medical documentation is required to substantiate the frequency. A diagnosis of renal disease is not sufficient. The nature of the illness or injury (diagnosis, complaint, or symptom) requiring the performance of the test(s) must be present on the claim. A diagnosis from the ICD-9-CM coding system may be shown in lieu of a narrative description.

Laboratory Tests For Hemodialysis, Peritoneal Dialysis, and CCPD Included in the Composite Rate

1. Per Treatment

   All hematocrit or hemoglobin and clotting time tests furnished incident to dialysis treatments.

2. Weekly

   Prothrombin time for patients on anti-coagulant therapy

   Serum Creatinine

   Weekly or Thirteen Per Quarter

   BUN

3. Monthly

Serum Calcium	Serum Bicarbonate	Alkaline Phosphatase
Serum Chloride	Serum Phosphorous	AST, SGOT
Total Protein	Serum Potassium	LDH
CBC	Serum Albumin	

Laboratory Tests For CAPD Included in the Composite Rate

Monthly

BUN	Magnesium	Alkaline Phosphatase
Creatinine	Phosphate	LDH
Sodium	Potassium	AST, SGOT
CO2	Total Protein	HCT
Calcium	Albumin	Hgb Dialysate Protein

A. Automated Profile Tests.--Clinical laboratory tests can be performed individually or in groups on automated profile equipment. If a clinical laboratory test is performed individually, it is paid in accordance with §§5114ff. If clinical laboratory tests are performed as part of an automated profile, then the following procedure applies:

1. Determine which of the laboratory tests in the automated profile are included under the composite rate and which are separately billable ESRD laboratory tests.

2. Determine the payment allowance of the automated profile by comparing it to the total payment allowances of the covered laboratory tests in the automated profile when the medically necessary tests in the profile are performed individually. The payment allowance of the automated profile is the lower of these two amounts. (See §5114.1.L.) If the payment allowance for the automated profile containing only the medically necessary tests is lower, you must determine the percentage of covered tests included under the composite rate payment. If 50 percent or more of the covered tests are included under the composite rate payment, then the entire profile is included within the composite payment. In this case, no separate payment in addition to the composite rate is made for any of the separately billable tests. If more than 50 percent of the covered tests are separately billable, the entire automated profile is considered separately billable. In this case, the entire automated profile is paid for in addition to the ESRD composite rate.

If the lower payment allowance is the payment allowance of the laboratory tests taken individually, the tests may be billed individually. In this case, the tests included under the composite rate are not billed or paid separately, and the tests that are not included under the composite rate are billed and paid separately.

B. Separately Billable Tests Furnished by Hospital-Based Facilities.--Hospital-based facilities are paid for the separately billable ESRD laboratory tests furnished to their outpatients following the same rules that apply to all other Medicare covered outpatient laboratory services furnished by a hospital.

C. Separately Billable Tests Furnished to Patients of Independent Dialysis Facilities.--All separately billable ESRD clinical laboratory services furnished to patients of independent dialysis facilities must be billed by and reimbursed to the person or entity that performs the laboratory test in accordance with usual Medicare program rules. Independent dialysis facilities with the appropriate clinical laboratory certification may perform and bill their intermediary for separately billable laboratory services. Independent dialysis facilities are paid for separately billable clinical laboratory tests according to the Medicare laboratory fee schedule for independent laboratories.

Following are tests not included in the composite rate which may be paid at the frequency shown without medical documentation. Tests in excess of that frequency require medical documentation. A diagnosis of ESRD alone is not sufficient medical documentation. The nature of the illness or injury (diagnosis, complaint, or symptom) requiring the performance of the test(s) must be present on the claim. A diagnosis from the ICD-9-CM coding system may be shown in lieu of a narrative description.

Guidelines for Separately Billable Tests for Hemodialysis, IPD, and CCPD

Serum Aluminum - one every 3 months

Serum Ferritin - one every 3 months

Guidelines for CAPD

Every 3 months

WBC
RBC
Platelet count

Every 6 months

Residual renal function
24 hour urine volume

Specimen Collection Fee.--(See §5ll4.6D for additional information concerning the specimen collection fee.) Allow separate charges made by independent laboratories for drawing or collecting specimens up to $3. Do not pay this fee to anyone who has not actually extracted the specimen from the patient. Only one collection fee is allowed for each patient encounter, regardless of the number of specimens drawn. When a series of specimens is required to complete single tests, treat the series as a single encounter. Allow a specimen collection fee in circumstances such as drawing a blood sample through venipuncture or collecting a urine sample by catheterization.

A specimen collection fee is not allowed when the specimen is taken to perform a laboratory test reimbursed under the composite rate. However, if a home dialysis patient selects reimbursement Method II and all other criteria for payment are met, pay an independent laboratory the specimen collection fee for specimens collected from the patient.

427l. HOME DIALYSIS PATIENTS' OPTIONS FOR BILLING

A. Medicare beneficiaries dialyzing at home, or as a home dialysis patient in an SNF, must choose one of two methods of program payment for their care.

Method I--The Composite Rate

If the Medicare home dialysis patient chooses Method I, the dialysis facility with which the home patient is associated must assume responsibility for providing all home dialysis equipment, supplies, and home support services. For these items and services, the facility receives the same Medicare dialysis payment it would receive for an infacility patient under the composite rate system. Under this arrangement, the beneficiary is responsible for paying any unmet Part B deductible amount and the 20-percent coinsurance on the Medicare rate to the facility. The FI processes all Method I claims.

Method II--Dealing Directly with a Home Dialysis Supplier

If a home dialysis beneficiary chooses Method II, he or she deals directly with a supplier of home dialysis equipment and supplies that is not a dialysis facility. There can be only one supplier per beneficiary and the supplier must accept assignment of Medicare benefits for all Method II supplies and equipment. The beneficiary is responsible for any unmet Part B deductible and the 20 percent coinsurance. Claims for Method II equipment and supplies are paid by the DMERCs.

All intermediaries and carriers will use the “S” trailer code to determine the reimbursement method selected by home dialysis ESRD patients. Use the “S” trailer in lieu of the paper listing.

B. Processing Home Dialysis Claims For Supplies and Equipment.--

- The DMERC must compare all claims for ESRD supplies and equipment to the method selection information in CWF. If CWF lists the beneficiary as a Method I patient for the dates of service shown on the claim, the DMERC must deny the claim.

- The DMERC must check the claim to determine if there is employer plan health insurance. (See §§3335ff. where the beneficiary is covered under employer plan health insurance.)

- If CWF currently lists the beneficiary as a Method II patient, the DMERC must process the claim. (See §4270.)

C. Changing Billing Option.--If a home dialysis ESRD beneficiary wants to change from one method of billing to the other, the beneficiary must obtain a Form CMS-382 from the ESRD facility, complete it, and return it to his or her ESRD facility. A beneficiary may file a new Form CMS-382 with the facility at any time during the year, but the changes are not effective until the beginning of the next calendar year. The only time a change in method selection would be effective on a date other than January 1 is when the beneficiary makes a written request to his or her FI for an exception to the January 1 effective date, and the FI decides to grant the exception.

4271.1 Payment for Dialysis Furnished to Patients Who are Travelling.--Patients who dialyze in an ESRD facility often arrange to dialyze temporarily in other facilities when they travel. Patients who usually receive dialysis in an ESRD facility may become home dialysis patients temporarily because they are travelling. In this situation, the patient may choose only payment Method I. DMERCs must not pay any of these claims. Facilities must submit all of their claims to their intermediaries. If the patient is not normally a home dialysis patient, and has no intention of becoming one except for a temporary period; e.g., a vacation, then the patient does not complete Form CMS-382, Beneficiary Selection Form. Instead, the RO acts as the focal point to ensure that the claims are processed appropriately.

4272. MONTHLY CAPITATION PAYMENTS FOR PHYSICIAN'S SERVICES TO MAINTENANCE DIALYSIS PATIENTS

The monthly capitation payment (MCP) for maintenance dialysis is a comprehensive monthly payment that covers all physician's services associated with the continuing medical management of a maintenance dialysis patient. The MCP is one of two ways that these physician services are paid. See §§2230, 5037 and 5211.1 for further discussions on coverage and payment rules regarding the MCP. See §4275 for the initial method of payment for these services.

Local carriers must pay for services in addition to the MCP, if they meet the requirements in §5037.1.

4272.1 Billing Requirements for the Monthly Capitation Payment.--When physicians are paid the MCP the following requirements apply:

- The MCP is made by the local carriers.
- Only one MCP may be billed for any patient.
- The claim for the MCP must be filed after the month during which services are furnished.
- Physician's services furnished outside the usual dialysis setting may be billed separately or included in the MCP. (See §§4272.2E2 and 4272.4.)
- Services for which additional payment is appropriate; e.g., inpatient hospital visits, must be billed on the same claim form as the MCP. If assignment is taken for the MCP, but not for the other individual services on the same claim, the physician checks the "yes" block in item 26, Form CMS-1500, and adds the words, "for MCP only".
- Payment by this method may be made to the physician who accepts assignment, or to the beneficiary when the physician does not accept assignment.
- The physician uses Form CMS-1500 to bill Medicare.
- When the physician does not accept assignment, he/she must furnish the patient a bill that fully identifies that it is a bill for the MCP.
- If the physician furnishing the service is a member of a professional corporation or a similar group or clinic, he/she must be identified on the claim form.

4272.2 Data Elements Required for Claims for Payment under the Monthly Capitation Payment Method.--

A. Elements 1 through 13 of Form CMS-1500 are completed in accordance with the instructions in §§4011ff.

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

C. Element 21 of Form CMS-1500 (or the itemized bill) must contain the name and address of the facility involved with the patient's maintenance care or training.

D. Element 23A of Form CMS-1500 (or the itemized bill) must show the diagnosis, and whether the patient is in training for self-dialysis. Element 23B is left blank.

E. Element 24A of Form CMS-1500 (or the itemized bill) must show the dates of service during the month that are included in the MCP. The period includes:

1. The full month if the patient was dialyzed in the usual setting; or

2. The full month if the patient was an inpatient for part of the month and the attending physician does not elect to bill separately for inpatient services. In this case, the MCP covers all services furnished during the inpatient stay. The physician may not bill fee-for-service for any inpatient care; or

3. The full month less the days when the patient was not in the care of the attending physician (or the physician's substitute), or when the attending physician chooses to bill separately for services furnished outside of the usual setting.

F. Element 24C of Form CMS-1500 (or the itemized bill) must show the initials "MCP" as the indicator needed to identify the claim as a request for the MCP. Also use this element to indicate "temporary patient" per §4272.4.

G. The remainder of Form CMS-1500 is completed in accordance with the general instructions in §§4010ff. and 4011ff.

4272.3. Controlling Claims Paid under the Monthly Capitation Payment Method.--In order to adequately control utilization and duplicate payments, you must be able to identify dialysis patient history records and the files of physicians who furnish services related to dialysis.

In processing claims reimbursed under this method, you must assure that:

A. Only one monthly payment is made for any renal disease patient per month; and

B. Duplicate charges billed as a duplicate MCP or as separate charges for services covered by the monthly payment are denied; and

C. Concurrent services by another physician that are covered in the attending physician's MCP are only covered and reimbursed in accordance with the rules in §§4272.2E2, 4272.4 and 5037.5; and

D. The days in which the patient was not maintained in the usual setting per §4272.2E above are excluded from the MCP. The MCP is prorated at 1/30th the MCP for each day of absence from the usual setting. See §52ll.l for reimbursement instructions.