# Medicare
# Carriers Manual
## Part 3 - Claims Process

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

**Transmittal 1743** **Date: MARCH 5, 2002**

**CHANGE REQUEST 1799**

| HEADER SECTION NUMBERS | PAGES TO INSERT | PAGES TO DELETE |
|---|---|---|
| Table of Contents, Chapter 4 | 4 – 4.1 – 4-2 (2 pp.) | 4 – 4.1 – 4-2 (2 pp.) |
| 4270.1 (Cont.) – 4270.2 | 4-67.1a – 4-67.1b (2pp.) | 4-67.1a - 4-67.1b (2 pp.) |
| 4271 - 4272.4 (Cont.) | 4-67.4 - 4-68.3 (5 pp.) | 4-67.4 - 4-68.4 (5 pp.) |

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

Section 4270.1, Home Dialysis Supplies and Equipment is being updated to replace references to the "ZX" modifier with the new permanent national modifier "KX". Since the original release of Change Request (CR) 1799, Transmittal 1729, CMS released CR 1948. CR 1948 replaced the DMERC local modifier "ZX" with a new, permanent national modifier "KX". We are issuing this transmittal to bring the affected sections of the MCM up to date with the new modifier.

**MANUALIZATION/CLARIFICATION - EFFECTIVE/IMPLEMENTATION DATES: Not Applicable.**

Section 4271.2, Payment for Method II Home Dialysis Supplies when the Beneficiary is an Inpatient manualizes CR 1288, Transmittal AB-00-124.

**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.**

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home. Effective July 1, 2002, suppliers must use the "KX" 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 "KX" 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 "KX" 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.

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.

4271.2 Payment for Method II Home Dialysis Supplies when the Beneficiary is an Inpatient.— Method II suppliers may bill Medicare only for the amount of supplies that a beneficiary actually used in the month before the supplier submits a monthly claim. Therefore, in the month following a home dialysis patient's inpatient stay, the supplier must reduce the monthly delivery of, and billing for, new supplies to account for the supplies the Method II patient did not use during his or her inpatient stay. Home dialysis patients may retain one month's worth of emergency supplies. Therefore, the effect of this limitation on new supplies is that the home dialysis patient will have sufficient supplies on hand to last for one month, but no more than one month.

This policy applies only to Method II patients who have had an inpatient stay lasting at least 3 days, not including the date of admission or the date of discharge.

If the inpatient stay begins at the end of one month, and carries over into the following month, suppliers should prorate their bills for the month following the second month of the inpatient stay. For example, if a beneficiary becomes an inpatient on February 26 and remains an inpatient until March 5, the supplier would prorate the bill it submits for dialysis supplies for the following April. The proration would also need to take the days in February (not including the date of admission) that the beneficiary was an inpatient into account when prorating the April bill in this example.

Suppliers must prorate from the allowed charge (the monthly cap), rather than their submitted charges.

CMS requires that all Method II dialysis suppliers have a written agreement with a support service renal facility, which maintains the beneficiary's medical records. Method II suppliers should encourage support service facilities to notify them when the facility becomes aware that a beneficiary became an inpatient for part of a month. When the support service facility notifies the supplier of a beneficiary's inpatient stay, the supplier must prorate its bill for the next month's supplies for that beneficiary. Similarly, suppliers should request that the beneficiaries they service inform the supplier when they are an inpatient.

DMERCs must not apply this reduction to equipment rental, since the beneficiary does not return the equipment to the supplier during a period of hospitalization. Therefore, the supplier may continue to bill in full for the rental of home dialysis equipment.

As with any other Medicare claims, the supplier billing for home dialysis supplies and equipment must complete all required information on the claim form, including any codes or modifiers required by CMS or its contractors.

If the DMERCs discover, through their normal data analysis activities, that this activity is presenting a significant vulnerability to the Medicare program, they must take the appropriate corrective action. Chapter 3 of the Program Integrity Manual provides more direction on the application of appropriate corrective actions.

## 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.

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.

Example 1.--Dr. Smith claims a reduced MCP to account for 10 days when the patient was in the hospital. He also claims separate payment for the services he furnished to the patient in the hospital. Verify that the dates of service on the separate claims do not overlap and that the services are reasonable and necessary.

Example 2.--Same as Example 1 except that you also receive a claim for services by Dr. Jones for inpatient services. Verify that the services by Dr. Jones are reasonable and necessary and are not covered by the MCP or any payments made for services billed by Dr. Smith. Dr. Smith's services must meet the general coverage requirements for concurrent services in §2020F.

Example 3.--Dr. Smith claims a full MCP but Dr. Jones bills for dialysis services furnished while the patient was in the hospital. Prorate Dr. Smith's monthly payment by 1/30th for each day that the patient was in the hospital. (See §4272.2E.)

E. By a periodic review of a randomly selected sample of patients' histories with reimbursement under the MCP method, the number of and types of services billed separately from the MCP are appropriate considering the individual patient's medical condition.

Verification of periods covered by the MCP may sometimes be done after the claim for the MCP has been processed depending upon the sequence of receipt of the claims.

4272.4. Physician's Services Furnished to a Dialysis Patient Away from Home or Usual Facility.--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:

A. The physician who furnished the service submits a claim to the local carrier of jurisdiction, if the physician accepts assignment; or

B. The beneficiary may file a nonassigned claim to the local carrier where the service was furnished, or with some other carrier. The carrier with jurisdiction over the location where the service was furnished has jurisdiction just as is the case for other types of services.

C. Process the claims within your jurisdiction without reference to the files of the carrier that has jurisdiction over the usual place for maintenance dialysis, and send a copy of the Explanation of Medicare Benefits (EOMB) to the carrier in such service area. Ensure that the home address of the beneficiary and the identity of the carrier that has jurisdiction over the usual dialysis setting, if known, is indicated on the claim.

D. The carrier that has jurisdiction over the usual dialysis setting adjusts the MCP to the usual attending physician per §4272.2E to account for the time the patient was absent from the usual dialysis setting.

Notify your 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" under element 24C of the form HCFA-l500.

**(NEXT PAGE IS 4-68.4A)**