FACT SHEET

END STAGE RENAL DISEASE (ESRD) AND DIALYSIS-RELATED SERVICES

CMS Medicare Benefit Policy Manual (Pub. 100-02), Chapter 11

Dialysis services furnished to hospital inpatients are covered under Medicare Part A and paid in accordance with applicable payment rules.

Medicare Part B covers the services listed below (unless otherwise noted).

- Dialysis
  - Hemodialysis (see section 50.A.1 for payment information)
  - Peritoneal (see section 50.A.4 for payment information)
  - Hemofiltration (see section 50.A.2 for payment information)
  - Ultrafiltration (see section 50.A.3 for payment information)

Outpatient Physician Dialysis Visits

Physicians and practitioners who manage center-based patients on dialysis are paid

a monthly capitation rate (MCP) for most outpatient dialysis-related physician services. Key points:

- Report CPT codes 90951 -90962 once per month to distinguish age- specific services performed in an outpatient setting, based on the number of face-to-face visits provided.
- Report CPT codes 90963-90966 once monthly for home dialysis patients.
- The physician or practitioner, who provides the complete assessment, establishes the patient's plan of care and provides ongoing management, should be the one who submits a claim for the monthly service.

Submit the following monthly visit CPT codes for patients 20 years of age or older:

- 90962 - When providing one face-to-face visit per month;
- 90961 - When providing two to three face-to-face visits per month;
- 90960 - When providing four or more face-to-face visits per month.

Claim submission:

- For purposes of submitting physician and practitioner ESRD-related services:
  - The term 'month' means a calendar month. The first month in which the beneficiary begins dialysis treatment marks the beginning of treatments through the end of the calendar month. Thereafter, the term 'month' refers to a calendar month.
  - In determining the appropriate age for ESRD-related services code, the age of the beneficiary is based on his/her age at the end of the month.
  - Visits must be furnished face-to-face by a physician, clinical nurse specialist, nurse practitioner, or physician's assistant.

Hemodialysis and Peritoneal Dialysis Hemodialysis – 3 sessions per week (if the number of sessions exceed this frequency medical justification is required.

Required Documentation:

- Signed physician/nonphysician practitioner order
- Signed note for EACH face-to-face visit during the billing period

Medicare allows only the medically necessary portion of a visit. Even if a complete note is generated, only the necessary services for the condition of the patient at the time of the visit can be considered in determining the level/medical necessity of any service.

End Stage Renal Disease (ESRD) occurs from the destruction of normal kidney tissues over a long period of time. Often there are no symptoms until the kidney has lost more than half its function. The loss of kidney function in ESRD is usually irreversible and permanent.

ESRD facilities must be certified by Medicare and are required to comply with the Conditions for Coverage set forth in 42 CFR Part 494. Survey and certification information for ESRD facilities is available on the CMS website: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Dialysis.html.

This Fact Sheet is for informational purposes only and is not intended to guarantee payment for services, all services submitted to Medicare must meet Medical Necessity guidelines. The definition of "medically necessary" for Medicare purposes can be found in Section 1862(a)(1)(A) of the Social Security Act – Medical Necessity (http://www.ssa.gov/OP_Home/ssact/title18/1862.htm).

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- The physician or practitioner, who provides the complete assessment, establishes the patient's plan of care and provides ongoing management, should be the one who submits a claim for the monthly service

Visit Documentation Requirements:

A. Visits may be furnished by another physician or practitioner (who is not the Monthly Capitation Payment (MCP) physician or practitioner).
   - If the MCP physician or practitioner relies on other physicians or qualified nonphysician practitioners to provide some of the visits during the month:
   - The MCP physician or practitioner does not have to be present when these other physicians or practitioners provide visits.
   - Physicians or practitioners provide visits. The non-MCP physician or practitioner must be a partner, an employee of the same group practice, or an employee of the MCP physician or practitioner.

B. When another physician or practitioner furnishes some of the visits during the month, the physician who provides the complete assessment, establishes the patient's plan of care, and provides the ongoing management, should submit the claim for the MCP service.
   - If a nonphysician practitioner (NPP) performs the complete assessment and establishes the plan of care, the MCP service should be submitted under the Provider Transaction Access Number (PTAN) of the clinical nurse specialist, nurse practitioner, or physician's assistant.

Home Dialysis Visits

Documentation:

- Signed physician/non-physician practitioner order
- Documentation to support the patient was trained to perform dialysis in the home environment
- Method, frequency and patient tolerance of dialysis session
- MUST support at least one face-to-face visit per month
- All labs/automated multi-channel chemistry (AMCC) results for both current and previous month

Monthly billing:

- Full month: CPT codes 90963, 90964, 90965, 90966
- Per day: CPT codes 90967, 90968, 90969, 90970
- Qualified non-physician practitioner other than MCP: CPT codes 90951 - 90966
- Partial Month
  - When patient receives home dialysis for 14 days and is hospitalized remainder of the month use the age appropriate CPT codes (90967-90970) and submit 14 units.
  - NOTE: the MCP must document a face-to-face visit
- Transient patients leaving home dialysis site:
  - Physician or practitioner responsible for transient care should submit appropriate number of days patient was under his/her care.
  - If documentation submitted supports that the MCP physician performed a face-to-face within the same month, he/she may submit a claim for dates on which face-to-face visits were performed.

Additional Information

- The term 'month' means a calendar month. The first month the beneficiary begins dialysis treatments is the date the treatments begin through the end of the calendar month. Thereafter, the term "month" refers to a calendar month.
- Beneficiary Determination age; the beneficiary's age at the end of the month determines the appropriate age related ESRD related services code.
- Qualifying visits under the MCP:
  - Face-to-face visits must be performed by a physician, clinical nurse specialist, nurse practitioner, or physician's assistant.
  - Visits furnished by another physician or practitioner who is not the MCP physician or practitioner: See CMS Medicare Benefit Policy Manual (Pub. 100-02), chapter 11 End Stage Renal Disease (ESRD): http://www.cms.gov/Regulations- and-Guidance/Guidance/Manuals/Downloads/bp102c11.pdf
- Please note that ALL services ordered or rendered to Medicare beneficiaries MUST be signed. Signatures may be handwritten or electronically signed.
  - You should NOT add late signatures to a medical record but instead make use of the signature authentication process outlined in MLN Matters article MM6698 (http://www. cms.gov/Outreach-and-Education/Medicare-Learning- Network-MLN/MLNMattersArticles/Downloads/MM6698. pdf). A sample attestation statement is available on the CGS website (http://www.cgsmedicare.com/partb/cert/ attestation_form.pdf).
  - Guidelines regarding signature requirements are located in the CMS Medicare Program Integrity Manual (Pub. 100-08), chapter 3, section 3.3.2.4 (http://www.cms.gov/Regulations- and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf)

References

CMS Medicare Benefit Policy Manual (Pub. 100-02), chapter 11 End Stage Renal Disease: http://www.cms.gov/Regulations-and-Guidance/ Guidance/Manuals/Downloads/bp102c11.pdf

CMS Medicare Benefit Policy Manual (Pub. 100-02), chapter 15 Covered Medical & Other Health Services: http://www.cms.gov/Regulations- and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

CMS Medicare Claims Processing Manual (Pub. 100-04), chapter 8, Outpatient ESRD Hospital, Independent Facility and Physician/ Supplier Claims: http://www.cms.gov/Regulations-and- Guidance/Guidance/Manuals/Downloads/clm104c08.pdf

CMS End Stage Renal Disease (ESRD) Center: http://www.cms.gov/Center/Special-Topic/End- Stage-Renal-Disease-ESRD-Center.html

ESRD Payment: https://www.cms.gov/medicare/ medicare-fee-for-service-payment/esrdpayment

CGS Local Coverage Determination (LCD) L37575, Frequency of Hemodialysis, https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=37575&ver=20&bc=0

CGS Local Coverage Determination (LCD) L34062, Dialysis Access Maintenance, https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=34062&ver=41&bc=0