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 2372

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents Chapter 4	4-4.1 – 4-4.2 (2pp.)	4-4.1 – 4-4.2 (2pp.)
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NEW/REVISED MATERIAL--*EFFECTIVE DATE: January 1, 2003*
IMPLEMENTATION DATE: January 1, 2003

Section 4271, Home Dialysis Patients' Options for Billing, is being updated to incorporate Program Memorandum AB-01-61.

Section 4271.2, Payment for Method II Home Dialysis Supplies when the Beneficiary is an Inpatient, is being deleted to remove the requirement for prorating ESRD claims when a patient in the hospital.

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.

Section

Provider-Based Physician Billing

Other Billings

Section

Medicare as Secondary Payer

Request for Information From the Public

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 Fiscal Intermediary (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 Durable Medical Equipment Regional Carriers (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.

- 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.

- 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.

C. Method Selection and Form CMS-382.--If an ESRD beneficiary chooses to participate in a self-dialysis training course and his or her physician certifies that it is reasonable to expect the beneficiary to complete the training program and self-dialyze on a regular basis, the beneficiary must fill out Form CMS-382 to choose either Method I or Method II dialysis. Once a beneficiary has made a method selection, the dialysis facility submits the Form CMS-382 to the appropriate FI. The FI then enters the information from this form into the Common Working File (CWF). (See §4270)

D. Changes in Method Selection.--If a beneficiary decides to change his or her choice of method, he or she must fill out a new Form CMS-382 to indicate the change. The beneficiary may fill out a new method selection form at any time, but in most circumstances, the change will not take effect until January 1 of the following calendar year. If a beneficiary requests an exception to the January 1 implementation date in writing from the FI, the FI may choose to grant his or her request.

Examples:

A. A beneficiary decides to change his or her method from Method I to Method II, and completes a new CMS-382 on October 1, 2002. The beneficiary signs the form on October 1, 2002 and does not request an exception to the January 1 effective date.

In this example, the FI enters an effective date of January 1, 2003 for the beneficiary's change to Method II. The beneficiary remains a Method I patient through December 31, 2002, and the FI continues to process his or her claims with dates of service on and before that date. The DMERC begins processing Method II claims for dates of service on and after January 1, 2003. The beneficiary remains a Method II patient until he or she decides to complete a new CMS-382 to change his or her method selection.

B. A beneficiary decides to change his or her method from Method I to Method II and completes a new CMS-382 on October 1, 2002. The beneficiary signs the form on October 1, 2002 and requests and exception to the January 1 effective date. The FI decides to grant the request for the exception and grants the beneficiary an effective date of November 1, 2002 for the change.

In this example, the FI enters an effective date of November 1, 2002 for the beneficiary's change to Method II. The beneficiary remains a Method I patient for dates of service before November 1, 2002, and the FI continues to process his or her claims with dates of service before that date. The DMERC begins processing Method II claims for dates of service on and after November 1, 2002. The beneficiary remains a Method II patient until he or she decides to complete a new CMS-382 to change his or her method.

C. A beneficiary decides to change his or her method from Method I to Method II and completes a new CMS-382 on October 1, 2002. The beneficiary signs the form on October 1, 2002 and requests and exception to the January 1 effective date. The FI decides to deny the request for an exception to the January 1 effective date

In this example, the FI enters an effective date of January 1, 2003 for the beneficiary's change to Method II. The beneficiary remains a Method I patient through December 31, 2002, and the FI continues to process his or her claims with dates of service on and before that date. The DMERC begins processing Method II claims for dates of service on and after January 1, 2003. The

beneficiary remains a Method II patient until he or she decides to complete a new CMS-382 to change his or her method.

4271.1 Payment for Dialysis Furnished to Patients Who are Traveling.--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 traveling. 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.

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 CMS-l500.

(NEXT PAGE IS 4-68.4A)