Program Memorandum Intermediaries/Carriers

Department of Health and Human Services (DHHS)

HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal AB-00-44 **Date: MAY 2000**

CHANGE REQUEST 1118

SUBJECT: Medicare Coverage of Non-Invasive Vascular Studies When Used to Monitor the Access Site of End Stage Renal Disease (ESRD) Patients

This Program Memorandum clarifies the application of a long standing Medicare policy regarding services included in the composite rate for ESRD patients. Medicare pays for outpatient maintenance dialysis services furnished by ESRD facilities based on a composite payment rate. This rate is a comprehensive payment and includes all services, equipment, supplies, and certain laboratory tests and drugs that are necessary to furnish a dialysis treatment.

For dialysis to take place, there must be a means of access so that the exchange of waste products may occur. As part of the dialysis treatment, ESRD facilities are responsible for monitoring access, and when occlusions occur, either declot the access or refer the patient for appropriate treatment. Procedures associated with monitoring access involve taking venous pressure, aspirating thrombus, observing elevated recirculation time, reduced urea reduction ratios, or collapsed shunt, etc. All such procedures are covered under the composite rate.

A number of ESRD facilities are monitoring access through non-invasive vascular studies such as duplex and Doppler flow scans and billing separately for these procedures. Non-invasive vascular studies are not covered as a separately billable service if used to monitor a patient's vascular access site. Medicare pays for the technical component of the procedure in the composite payment rate.

An ESRD facility must furnish all necessary services, equipment, and supplies associated with a dialysis treatment, either directly or under arrangements that make the facility financially responsible for the service. If an ESRD facility or a renal physician decides to monitor the patient's access site with a non-invasive vascular study and does not have the equipment to perform the procedure, the facility or physician may arrange for the service to be furnished by another source. The alternative source, such as an independent diagnostic testing facility must look to the ESRD facility for payment. No separate payment for non-invasive vascular studies for monitoring the access site of an ESRD patient, whether coded as the access site or peripheral site, is permitted to any entity.

Where there are signs and symptoms of vascular access problems, Doppler flow studies may be used as a means to obtain diagnostic information to permit medical intervention to address the problem. Doppler flow studies may be considered medically necessary in the presence of signs or symptoms of possible failure of the ESRD patient's vascular access site, and when the results are used in determining the clinical course of the treatment for the patient. However, if the Doppler flow study is appropriate, then other diagnostic services, such as venography, would be considered duplicative services and would not be covered by Medicare.

The only Current Procedural Terminology (CPT) billing code for non-invasive vascular testing of a hemodialysis access site is 93990. Deny separate billing of the technical component of this code if it is performed on any patient for whom the ESRD composite rate for dialysis is being paid, unless there is appropriate medical indication of the need for a Doppler flow study. Contractors should develop local medical review policy (LMRP) to determine when payments for Doppler flow studies are appropriate.

LMRPs are those policies used to make local medical coverage decisions under the authority of §1862(a)(1)(A) of the Social Security Act in the absence of specific statute, regulations or national coverage policy, or as adjunct to a national coverage policy. LMRPs provide guidance on whether an item/service(s) is covered and under what clinical circumstance it is considered reasonable, necessary, and appropriate for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member. To determine if an LMRP is needed, consult the medical director, physician staff, medical review manager and/or staff. An LMRP may be needed when an item or service appears not to be medically reasonable or necessary.

When the Doppler flow study is determined to be medically necessary, payment should be limited to either this study or other appropriate vascular study, but not both. Examples of medical necessity for Doppler flow studies could include:

a. Elevated venous pressure > 200mm HG on a 200 cc/min. pump,
b. Elevated recirculation of time of 12 percent or greater, and
c. Low urea reduction rate < 60 percent.

However, as a general rule, we would not expect ESRD facilities/nephrologists to order diagnostic Doppler flow studies since patients exhibiting vascular access problems are referred to a radiologist or surgeon for appropriate intervention. The radiologist or surgeon would determine the appropriate imaging study needed to determine the clinical course of treatment for the patient. We would expect that ESRD facilities/nephrologists would consult with the appropriate specialist before ordering imaging studies that would be necessary for clinical intervention of access failures. This policy is applicable to claims from ESRD facilities and all other sources, such as independent diagnostic testing facilities, or hospital outpatient departments.

The professional component of the procedure is included in the monthly capitation payment (MCP) (see §15060.1 of Medicare Carriers Manual, Part 3). The professional component should be denied for code 93990 if billed by the MCP physician. Medically necessary services that are included or bundled into the MCP (e.g., test interpretations) are separately payable when furnished by physicians other than the MCP physician. (See §§15060.1 and 15060.2 of the Medicare Carriers Manual, Part 3.)

If the claim is denied, report this on a remittance advice with group code "CO" and claim adjustment reason code 24, "Payment for charges denied. Charges are covered under a capitation agreement."

The Medicare Summary Notice denial message number is 16.32, "Medicare does not pay separately for this service." (See §3726.14A of the Medicare Intermediary Manual, Part 3.)

Billing for monitoring of hemodialysis access using CPT codes for non-invasive vascular studies other than 93990 is considered a misrepresentation of the service actually provided and should be considered for fraud investigation. Conduct data analysis on a periodic basis for non-invasive diagnostic studies of the extremities (including CPT codes 93922, 93923, 93924, 93925, 93926, 93930, 93931, 93965, 93970, 93971). Handle aberrant findings under normal program safeguard processes by taking whatever corrective action you deem necessary.

The *effective date* for this Program Memorandum (PM) is October 1, 2000.

The *implementation date* for this PM is October 1, 2000.

These instructions should be implemented within your current operating budget.

This PM may be discarded after June 30, 2001.

If you have any questions, contact Jacqueline Johnson, (410) 786-4560.