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 2747

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
4270.1 - 4270.2	4-67 - 4-67.1b (4 pp.)	4-67 - 4-67.1b (4 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: October 1, 2003*
IMPLEMENTATION DATE: October 1, 2003

Section 4270, ESRD Bill Processing Procedures, is revised to bring this section of the MCM into compliance with MCM §3045.7(C).

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.

Durable Medical Equipment Regional Carriers (DMERCs) must publish this information in their next regularly scheduled bulletins and applicable listservs, and on their Web sites within 4 weeks of receiving this instruction.

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:

- o 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;
- o Furnishing dialysis-related emergency services;
- o Consultation for the patient with a qualified social worker and a qualified dietician;
- o Maintaining a recordkeeping system which assures continuity of care;
- o Maintaining and submitting all required documentation to the ESRD network;
- o Assuring that the water supply is of the appropriate quality;
- o Assuring that the appropriate supplies are ordered on an ongoing basis;
- o Arranging for the provision of all ESRD related laboratory tests;
- o Testing and appropriate treatment of water used in dialysis;
- o Monitoring the functioning of dialysis equipment;
- o All other necessary dialysis services as required under the ESRD conditions for coverage; and
- o 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 "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 deny 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 deny Method II claims that do not have the "KX" modifier.

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