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 1910

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3005.4 (Cont) – 3005.4 (Cont)	3-14.7 – 3-14.8 (2 pp.)	3-14.7 – 3-14.8 (2 pp.)
3060.6 – 3060.6 (Cont.)	3-53 – 3-54 (2 pp.)	3-53 – 3-54 (2 pp.)
Table of Contents – Chapter IV	4-3 – 4-4 (2 pp.)	4-3 – 4-4 (2 pp.)
4020.2 (Cont) – 4020.2 (Cont.)	4-20.3 – 4-20.4 (2 pp.)	4-20.3 – 4-20.4 (2 pp.)
4175.1 – 4176.1 (Cont.)	4-45.1G – 4-45.1L (6 pp.)	4-45.1G – 4-45.1K (5 pp.)

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

Section 3005.4, is revised to delete the information pertaining to the "attending physician, not hospice employee" attestation statement. This attestation statement has been replaced with a new GV modifier.

Section 3060.6, is revised to allow the use of the Q5 reciprocal billing modifier by a hospice patient's designated attending physician when another group member provides services on behalf of the designated attending physician.

Section 4020.2, is revised to delete the block 19 attestation statement pertaining to hospice patient attending physician services. The attestation statement has been replaced with a new GV modifier.

Section 4175, Claims Involving Beneficiaries Who Have Elected Hospice Coverage, is revised to transfer the attending physician billing information to §4175.1.

Section 4175.1, Processing Claims For Attending Physician Services Furnished to Hospice Patients, revises the billing instructions and implements a newly created GV modifier for hospice patient attending physician services. The instructions are revised to permit substitute physician services to be billed by the designated attending physician under the reciprocal and locum tenens provisions.

Section 4175.2, Services Unrelated to a Hospice Patients Terminal Condition, is new information regarding the use of a new modifier GW for billing services not related to a hospice patients terminal condition.

Section 4175.3, Non-Hospice Services Furnished to Hospice Patients Who Are M+C Enrollees, provides information for processing fee for service claims for M+C benefciaries who have elected hospice coverage.

Section 4175.4, Payment Safeguard, is revised and was formerly §4175.3.

Section 4175.5, Medicare Summary Notices (MSNs) and Explanation of Medicare Benefits (EOMB) and Remittance Advice Messages, designates the MSN/EOMB/RA messages for denying non-attending physician services furnished to hospice patients.

Section 4175.6, Furnish Physicians With Information About Hospice Benefits, is revised and was formerly §4175.1

These instructions should be implemented within your current operating budget.

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.

j. If a date of service extends more than one day and a valid "to" date (MMDDCCYY) is not present in Field 24A. (Eight-digit date formats are effective of 10/01/98.)

k. If an "unlisted procedure code" or a "not otherwise classified" (NOC) code is indicated in Item 24D, but an accompanying narrative is not present in Item 19 or on an attachment.

l. If the name, address or NPI of the facility where services were furnished in a hospital, clinic, laboratory, or facility other than a patient's home or physician's office is not entered in Field 32, or the word "SAME."

2. Claim Specific Requirements.--The following instruction describes some "conditional" requirements which are claim specific, and necessary for processing a Part B claim submitted on the Form CMS-1500 (hardcopy) or the NSF (electronic). This instruction is minimal and does not include all "conditional" data element requirements which are claim specific.

Items from the Form CMS-1500 have been provided. These items are referred to as fields in the instruction. Refer to §3005.3 for a crosswalk between Form CMS-1500 items (hardcopy) and records and fields on the NSF (electronic).

NOTE: Some claim types covered by Part B are not included in these instructions. Also, the "SAME" requirement listed below only applies to paper claims.

Do not return claims as unprocessable if the NPI is at least eight digits in length, and valid.

Return the following claim as unprocessable to the provider of service/supplier:

a. For chiropractor claims:

1. If the x-ray date(s) (MMDDCCYY) is not entered in Field 19. (Eight-digit date formats are effective as of 10/01/98.)

2. If the initial date (MMDDCCYY) "actual" treatment occurred is not entered in Field 14. (Eight-digit date formats are effective as of 10/01/98.)

b. For certified registered nurse anesthetist (CRNA) and anesthesia assistant (AA) claims, if the CRNA or AA is employed by a group (such as a hospital, physician, or ASC) and they do not enter the group's name, address, or NPI number in Field 33 and their personal NPI number in Field 24J and K.

c. For durable medical, orthotic, and prosthetic claims, if the name, address, or NPI of the location where the order was accepted is not entered in Field 32, or the word "SAME" (DMERC's only).

d. For physicians who maintain dialysis patients and receive a monthly capitation payment:

1. If the physician is a member of a professional corporation, similar group, or clinic, and the attending physician's NPI is not entered in Field 24J and K.

2. If the name, address, or NPI of the facility involved with the patient's maintenance of care and training is not entered in Field 32, or the word "SAME."

e. For routine foot care claims, if the date the patient was last seen and the attending physician's NPI are not present in Field 19.

f. For immunosuppressive drug claims, if a referring/ordering physician was used and their name and/or NPI are not present in Fields 17 or 17A.

g. For all laboratory services, if the services of a referring/ordering physician are used and his or her name and/or NPI are not present in Fields 17 or 17A.

h. For laboratory services performed by a participating hospital-leased laboratory or an independent laboratory (including services to a patient at home or in an institution), if the name, address, or NPI of the laboratory where services were performed is not in Field 32, or the word "SAME".

i. For independent laboratory claims:

1. Involving EKG tracing and the procurement of specimen(s) from a patient at home or in an institution, if the claim does not contain a validation from the prescribing physician that any laboratory service(s) performed were conducted at home or in an institution by entering the appropriate annotation in Field 19 (i.e. - "Homebound").

2. If the name, address or NPI where the test was performed is not entered in Item 32, or the word "SAME."

j. For mammography "diagnostic" and "screening" claims, if a qualified screening center does not accurately enter their six-digit, FDA-approved certification number in Field 32 when billing the technical or global component.

k. For parenteral and enteral nutrition claims, if the services of an ordering/referring physician(s) are used and their name and/or NPI is not present in Field 17 or 17A.

l. For portable x-ray services claims, if the ordering physician's name and/or NPI are not entered in Fields 17 or 17A.

m. For radiology and pathology claims for hospital inpatients, if the referring/ordering physician's name and/or NPI (if appropriate) are not entered in Fields 17 or 17A.

n. For outpatient services provided by a qualified, independent physical or occupational therapist:

1. If the NPI of the attending physician is not present in Field 19.

2. If the date the patient was last seen (MMDDCCYY) by the attending physician is not present in Field 19.

o. For all laboratory work performed outside a physicians office, if the claim does not contain a name, address or NPI where the laboratory services were performed in Field 32, or the word "SAME."

p. For all physician claims, if an ICD-9CM code in Field 21 is missing, invalid or truncated.

q. For all physician office laboratory claims, if a 10-digit CLIA certification number is not present in Field 23.

o The physician or medical group providing the interpretations does not see the patient.

o The purchaser (or employee, partner, or owner of the purchaser) performs the technical component of the test. The interpreting physician must be enrolled in the Medicare program. No formal reassignment is necessary.

The purchaser must keep on file the name, the provider identification number and address of the interpreting physician. The rules permitting claims by a facility or clinic for services of an independent contractor physician on the physical premises of the facility or clinic are set forth in §§3060.2 and 3060.3C.

3060.6 Payment Under Reciprocal Billing Arrangements.--

A. General.--The patient's regular physician may submit the claim, and (if assignment is accepted) receive the Part B payment, for covered visit services (including emergency visits and related services) which the regular physician arranges to be provided by a substitute physician on an occasional reciprocal basis, if:

o The regular physician is unavailable to provide the visit services;

o The Medicare patient has arranged or seeks to receive the visit services from the regular physician;

o The substitute physician does not provide the visit services to Medicare patients over a continuous period of longer than 60 days; and

o The regular physician identifies the services as substitute physician services meeting the requirements of this section by entering in item 24d of Form CMS-1500 HCPCS Q5 modifier (service furnished by a substitute physician under a reciprocal billing arrangement) after the procedure code. When Form CMS-1500 is next revised, provision will be made to identify the substitute physician by entering his/her unique physician identification number (UPIN) on the form and cross-referring the entry to the appropriate service line item(s) by number(s). Until further notice, the regular physician must keep on file a record of each service provided by the substitute physician, associated with the substitute physician's UPIN, and make this record available to you upon request.

If the only substitution services a physician performs in connection with an operation are post-operative services furnished during the period covered by the global fee, these services need not be identified on the claim as substitution services.

A physician may have reciprocal arrangements with more than one physician. The arrangements need not be in writing.

B. Definitions.--

1. Covered Visit Service.--The term "covered visit service" includes not only those services ordinarily characterized as a covered physician visit, but also any other covered items and services furnished by the substitute physician or by others as incident to his/her services.

Items and services furnished by the staff of the substitute physician covered as incident to his/her services if billed by him/her are still covered if billed by the regular physician under this section.

Items and services furnished by the staff of the regular physician covered as incident to his/her services if furnished under his/her supervision are still covered if furnished under the supervision of the substitute physician.

2. Continuous Period of Covered Visit Services.--A continuous period of covered visit services begins with the first day on which the substitute physician provides covered visit services to Medicare Part B patients of the regular physician, and it ends with the last day on which the substitute physician provides these services to these patients before the regular physician returns to work. This period continues without interruption on days on which no covered visit services are provided to patients on behalf of the regular physician or are furnished by some other substitute physician on behalf of the regular physician. A new period of covered visit services can begin after the regular physician has returned to work.

EXAMPLE: The regular physician goes on vacation on June 30, 1992, and returns to work on September 4, 1992. A substitute physician provides services to Medicare Part B patients of the regular physician on July 2, 1992, and at various times thereafter, including August 30th and September 2, 1992. The continuous period of covered visit services begins on July 2nd and runs through September 2nd, a period of 63 days. Since the September 2nd services are furnished after the expiration of 60 days of the period, the regular physician is not entitled to bill and receive direct payment for them. The substitute physician must bill for these services in his/her own name. The regular physician may, however, bill and receive payment for the services which the substitute physician provides on his/her behalf in the period July 2nd through August 30th.

C. Unassigned Claims Under Reciprocal Billing Arrangements.--The requirements for the submission of claims under reciprocal billing arrangements are the same for assigned and unassigned claims.

D. Medical Group Claims Under Reciprocal Billing Arrangements.--The requirements of this section generally do not apply to the substitution arrangements among physicians in the same medical group where claims are submitted in the name of the group. On claims submitted by the group, the group physician who actually performed the service must be identified in the manner described in §3060.9, with one exception. When a group member provides services on behalf of another group member who is the designated attending physician for a hospice patient, the Q5 modifier may be used by the designated attending physician to bill for services related to a hospice patient's terminal illness that were performed by another group member .

For a medical group to submit assigned and unassigned claims for the covered visit services of a substitute physician who is not a member of the group, the requirements of subsection A must be met. The medical group must enter in item 24d of Form CMS-1500 the HCPCS modifier Q5 after the procedure code. Until further notice, the medical group must keep on file a record of each service provided by the substitute physician, associated with the substitute physician's UPIN, and make this record available to you upon request. In addition, the medical group physician for whom the substitution services are furnished must be identified by his/her provider identification number (PIN) in block 24k of the appropriate line item.

For an independent physician to submit assigned and unassigned claims for the substitution services of a physician who is a member of a medical group, the requirements of subsection A must be met. The independent physician must enter in item 24 of Form CMS-1500 HCPCS modifier Q5 after the procedure code. Until further notice, the independent physician must keep on file a record of each service provided by the substitute medical group physician, associated with the substitute physician's UPIN, and make this record available to you upon request.

Physicians who are members of a group but who bill in their own names are treated as independent physicians for purposes of applying the requirements of this section.

CHAPTER IV

Item 19. The 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) date patient was last seen and the UPIN of his/her attending physician when an independent physical or occupational therapist or physician providing routine foot care submits claims. For physical and occupational therapists, entering this information certifies that the required physician certification (or recertification) is being kept on file. (See §2206.1, Part 3 of MCM.)

The drug's name and dosage when submitting a claim for Not Otherwise Classified (NOC) drugs.

A concise description of an "unlisted procedure code" or a NOC code if one can be given within the confines of this box. Otherwise an attachment must be submitted with the claim.

All applicable modifiers when modifier -99 (multiple modifiers) is entered in item 24d. If modifier -99 is entered on multiple line items of a single claim form, all applicable modifiers for each line item containing a -99 modifier should be listed as follows: 1=(mod), where the number 1 represents the line item and "mod" represents all modifiers applicable to the referenced line item.

The statement "Homebound" when an independent laboratory renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient. (See §2051.1, Part 3 of MCM and §2070.1, Part 3 of MCM respectively, for the definition of "homebound" and a more complete definition of a medically necessary laboratory service to a homebound or an institutional patient.)

The statement, "Patient refuses to assign benefits" when the beneficiary absolutely refuses to assign benefits to a participating provider. In this case, no payment may be made on the claim.

The statement, "Testing for hearing aid" when billing services involving the testing of a hearing aid(s) is used to obtain intentional denials when other payers are involved.

When dental examinations are billed, the specific surgery for which the exam is being performed.

The specific name and dosage amount when low osmolar contrast material is billed, but only if

HCPCS codes do not cover them.

The 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) assumed and/or relinquished date for a global surgery claim when providers share post-operative care and/or relinquished date

Enter the pin (or UPIN when effective) of the physician who is performing a purchased interpretation of a diagnostic test (see MCM Part 3 §3060.5) for additional information.

Item 20. This item is completed when billing for diagnostic tests subject to purchase price limitations. The purchase price under charges must be shown if the "yes" block is checked. A "yes" check indicates that an entity other than the entity billing for the service performed the diagnostic test. A "no" check indicates that "no purchased tests are included on the claim." When "yes" is annotated, item 32 must be completed. When billing for purchased diagnostic tests, each test must be submitted on a separate claim form.

Item 21. The patient's diagnosis/condition. All physician and non-physician specialties (i.e., PA, NP, CNS, CRNA) must use an ICD-9-CM code number and code to the highest level of specificity. Enter up to four codes in priority order (primary, secondary condition). An independent laboratory must enter a diagnosis only for limited coverage procedures.

All narrative diagnoses for non-physician specialties must be submitted on an attachment.

Item 22. Leave blank. Not required by Medicare.

Item 23. The professional review organization (PRO) prior authorization number for those procedures requiring PRO prior approval.

The investigational device exemption (IDE) number when an investigational device is used in an FDA-approved clinical trial.

For physicians performing care plan oversight services, enter the 6-digit Medicare provider number of the home health agency (HHA) or hospice.

The 10-digit Clinical Laboratory Improvement Act (CLIA) certification number for laboratory services billed by an entity performing CLIA covered procedures.

Item 24a. The 6-digit (MM | DD | YY) or 8-digit (MMDDCCYY) date for each procedure, service, or supply. When "from" and "to" dates are shown for a series of identical services, enter the number of days or units in column C.

Item 24b. The appropriate place of service code(s) from the list provided in §4020.3. Identify the location, using a place of service code, for each item used or service performed.

NOTE: When a service is rendered to a hospital inpatient, use the "inpatient hospital" code.

Item 24c. Medicare Carriers must place the correct type of service indicator that matched the HCPCS procedure code, see §4020.G.

Item 24d. The procedures, services, or supplies using the Health Care Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.

The specific procedure code must be shown without a narrative description. However, when reporting an "unlisted procedure code" or a NOC code, include a narrative description in item 19 if a coherent description can be given within the confines of that box. Otherwise, an attachment must be submitted with the claim.

Item 24e. The diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Only one reference number per line item. When multiple services are performed, the primary reference number for each service; either a 1, or a 2, or a 3, or a 4 is shown.

If a situation arises where two or more diagnoses are required for a procedure code (e.g., pap smears), the provider must reference only one of the diagnoses in item 21.

Hospice Care

4175. CLAIMS INVOLVING BENEFICIARIES WHO HAVE ELECTED HOSPICE COVERAGE

Medicare beneficiaries entitled to hospital insurance (Part A) who have terminal illnesses and a life expectancy of 6 months or less have the option of electing hospice benefits in lieu of standard Medicare coverage for treatment and management of their terminal condition. Only care provided by a Medicare certified hospice is covered under the hospice benefit provisions.

Effective August 5, 1997, hospice care is available for two 90-day periods and an unlimited number of 60-day periods during the hospice patient's lifetime.

When hospice coverage is elected, the beneficiary waives all rights to Medicare Part B payments for services that are related to the treatment and management of his/her terminal illness during any period his/her hospice benefit election is in force, except for professional services of an "attending physician". For purposes of administering the hospice benefit provisions, an "attending physician" means a physician who:

- o Is a doctor of medicine or osteopathy; and

- o Is identified by the individual, at the time he/she elects hospice coverage, as having the most significant role in the determination and delivery of their medical care.

When hospice benefits are elected the hospice sends a notice of admission (NOA) form to both you and the intermediary. The NOA identifies the hospice, attending physician, and the terminal diagnosis. An indicator of the hospice election, the date of the hospice election, and the hospice's intermediary number are furnished to you by CWF in response to a submitted claim. All carriers which have submitted a claim automatically receive this notice. (See §6130.2.) Any discrepancies between the NOA and the CWF reply have to be corrected by the intermediary. Inform the intermediary of any discrepancy.

The hospice sends a copy of the notice to you and the intermediary when the beneficiary elects hospice coverage. The admission notice identifies both the attending physician and the hospice. Keep a copy of the data to use in processing hospice related claims. Keep the hospice identification number if the beneficiary is using the hospice physician but keep the name and identification number of both the physician and the hospice if the beneficiary is using a private attending physician.

4175.1 Processing Claims For Attending Physicians Who Treat Hospice Patients.--When a Medicare beneficiary elects hospice coverage he/she may designate an attending physician, not employed by the hospice, in addition to receiving care from hospice-employed physicians. The professional services of a non-hospice affiliated attending physician for the treatment and management of a hospice patient's terminal illness are not considered “hospice services”. These attending physician services are billed to you, provided they were not furnished under a payment arrangement with the hospice. The attending physician codes services with the GV modifier “Attending physician not employed or paid under agreement by the patient’s hospice provider” when billing his/her professional services furnished for the treatment and management of a hospice patient’s terminal condition. Make payment to the attending physician or beneficiary, as appropriate, based on the payment and deductible rules applicable to each covered service.

If another physician covers for the designated attending physician, the services of the substituting physician are billed by the designated attending physician under the reciprocal or locum tenens billing instructions. (See MCM 3060.6 and 3060.7.) In such instances, the attending physician bills using the GV modifier in conjunction with either the Q5 or Q6 modifier.

When services related to a hospice patient's terminal condition are furnished under a payment arrangement with the hospice by the designated attending physician, the physician must look to the hospice for payment. In this situation the physicians' services are hospice services and are billed by the hospice to its intermediary.

Process and pay for covered, medically necessary Part B services that physicians furnish to patients after their hospice benefits are exhausted or revoked even if the patient remains under the care of the hospice. Such services are billed without the GV or GW modifiers. Make payment based on applicable Medicare payment and deductible rules for each covered service even if the beneficiary continues to be treated by the hospice after hospice benefits are exhausted or revoked.

The CWF response contains the period of hospice entitlement. This information is a permanent part of the notice and is furnished on all CWF replies and automatic notices. Use the CWF reply for validating dates of hospice coverage and to research, examine and adjudicate services coded with the GV or GW modifiers.

4175.2 Services Unrelated to a Hospice Patients Terminal Condition--You may receive claims from physicians and suppliers for services not related to the hospice patient's terminal condition. These services are coded with the GW modifier "service not related to the hospice patient's terminal condition." Process services coded with the GW modifier in the normal manner for coverage and payment determinations. If warranted, you may conduct prepayment development or postpayment review to validate that services billed with the GW modifier are not related to the patient's terminal condition.

4175.3 Non-Hospice Services Furnished to Hospice Patients Who Are M+C Enrollees.--When an M+C enrolleee elects hospice coverage, you may receive fee for service claims from enrolled M+C organizations, physicians and suppliers who furnish non-hospice services to M+C enrollees. Process such services for coverage and payment determinations and submit claims transactions to CWF for payment authorization. Pay for medically necessary non-hospice services (i.e., services billed with either the GV or GW modifier) for M+C enrollees who elect hospice coverage based on applicable Part B payment and deductible rules.

4175.4 Payment Safeguards.--

- o Deny services billed by non-attending physicians who treat the hospice patient for the terminal condition. (See §4175.5.)

- o Determine if bills for DME, supplies, or independently practicing speech or physical therapists relate to the terminal condition. Deny DME, supplies, and independent speech and physical therapy claims related to the hospice patient's terminal condition. The hospice is required to bill and be paid for these services through it's intermediary. See §4175.2 for handling services unrelated to the hospice patient's terminal condition.

4175.5 Medicare Summary Notices (MSNs) and Explanation of Medicare Benefits (EOMB) and Remittance Advise Messages.--Use the following MSN or EOMB messages where appropriate.

If a claim is denied because it was submitted by a physician, other than the hospice patient's designated attending physician, who treated the beneficiary for the terminal condition use:

MSN #27.13, "According to Medicare hospice requirements this service is not covered because the service was provided by a non-attending physician."

o EOMB #20.4, "According to Medicare hospice requirements this service is not covered because the service was provided by a non-attending physician."

The spanish version of the above message is:

o Según requisitos de hospicio de Medicare este servicio no se cubre debido a que el servicio fue proporcionado por un médico no primario.

When the claim is being denied per the above reason, use the following code in the remittance advice message.

o Remark Code N90, "Covered only when performed by the attending physician."

4175.6 Furnish Physicians and Suppliers with Information about Hospice Benefits.--At least annually, include information in your newsletters and bulletins to physicians concerning the use of the GV modifier for coding attending physician services furnished for the treatment and management of a hospice patient's terminal condition. Inform them how to bill/code services performed by a covering physician. Also educate physicians and suppliers regarding the use of the GW modifier for coding/billing services not related to the hospice patient's terminal condition.

4176. PANCREAS TRANSPLANTS

Pancreas transplantation is performed to induce an insulin independent, euglycemic state in diabetic patients. The procedure is generally limited to those patients with severe secondary complications of diabetes, including kidney failure. However, pancreas transplantation is sometimes performed on patients with labile diabetes and hypoglycemic unawareness.

Effective July 1, 1999, Medicare will cover pancreas transplantation when it is performed in a licensed facility at the same time or after a kidney transplant (HCPCS code 50360 or 50365). If the pancreas transplant occurs after the kidney transplant, calculate the period of entitlement to immunosuppressive therapy beginning with the date of discharge from the admission for the pancreas transplant.

4176.1 Billing Instructions for Pancreas Transplants.--The following HCPCS code for pancreas transplants should appear in Block 24d of the CMS 1500:

o 48554 - Transplantation of pancreatic allograft.

Pancreas transplantation is reasonable and necessary for the following diagnosis codes. However, since this is not an all inclusive list, you are permitted to determine if any additional diagnosis codes will be covered for this procedure.

Diabetes Diagnosis Codes:

250.00 Diabetes mellitus without mention of complication, type II (non-insulin dependent) (NIDDM) (adult onset) or unspecified type, not stated as uncontrolled.

250.01 Diabetes mellitus without mention of complication, type I (insulin dependent) (IDDM) (juvenile), not stated as uncontrolled.

250.02 Diabetes mellitus without mention of complication, type II (non-insulin dependent) (NIDDM) (adult onset) or unspecified type, uncontrolled.

250.03 Diabetes mellitus without mention of complication, type I (insulin dependent) (IDDM) (juvenile), uncontrolled.

NOTE: X=0-3

250.1X Diabetes with ketoacidosis
250.2X Diabetes with hyperosmolarity
250.3X Diabetes with coma
250.4X Diabetes with renal manifestations
250.5X Diabetes with ophthalmic manifestations
250.6X Diabetes with neurological manifestations
250.7X Diabetes with peripheral circulatory disorders
250.8X Diabetes with other specified manifestations
250.9X Diabetes with unspecified complication

Hypertensive Renal Diagnosis Codes:

403.01 Malignant hypertensive renal disease, with renal failure

403.11 Benign hypertensive renal disease, with renal failure

403.91 Unspecified hypertensive renal disease, with renal failure

404.02 Malignant hypertensive heart and renal disease, with renal failure
404.03 Malignant hypertensive heart and renal disease, with congestive heart failure or renal failure

404.12 Benign hypertensive heart and renal disease, with renal failure
404.13 Benign hypertensive heart and renal disease, with congestive heart failure or renal failure

404.92 Unspecified hypertensive heart and renal disease, with renal failure
404.93 Unspecified hypertensive heart and renal disease, with congestive heart failure or renal failure

Chronic Renal Failure Code:

585

NOTE: If a patient had a kidney transplant that was successful, the patient no longer has chronic kidney failure, therefore it would be inappropriate for the provider to bill 585 on such a patient. In these cases one of the following V-codes should be present on the claim or in the beneficiary's history.

Use the following V-codes only when a kidney transplant was performed before the pancreas transplant:

V42.0 Organ or tissue replaced by transplant kidney
V43.89 Organ tissue replaced by other means, kidney or pancreas

NOTE: If the kidney and pancreas transplants are performed simultaneously, the claim should contain a diabetes diagnosis code and a renal failure code or one of the hypertensive renal failure diagnosis codes. The claim should also contain 2 transplant procedure codes. the claim is for a pancreas transplant only, the claim should contain a diabetes diagnosis code and a V-code to indicate a previous kidney transplant. If the V-code is not on the claim for the pancreas transplant, search the beneficiary's claim history for the V-code.

Chronic Renal Failure Code:

585

NOTE: If a patient had a kidney transplant that was successful, the patient no longer has chronic kidney failure, therefore it would be inappropriate for the provider to bill 585 on such a patient. In these cases one of the following V-codes should be present on the claim or in the beneficiary's history.

Use the following V-codes only when a kidney transplant was performed before the pancreas transplant:

V42.0 Organ or tissue replaced by transplant kidney
V43.89 Organ tissue replaced by other means, kidney or pancreas

NOTE: If the kidney and pancreas transplants are performed simultaneously, the claim should contain a diabetes diagnosis code and a renal failure code or one of the hypertensive renal failure diagnosis codes. The claim should also contain 2 transplant procedure codes. the claim is for a pancreas transplant only, the claim should contain a diabetes diagnosis code and a V-code to indicate a previous kidney transplant. If the V-code is not on the claim for the pancreas transplant, search the beneficiary's claim history for the V-code.

A. Medicare Summary Notice (MSN), Explanation of Your Medicare Benefits (EOMB), and Remittance Messages.--If a claim for simultaneous pancreas-kidney transplantation or pancreas transplantation following a kidney transplant is submitted to you and is missing one of the appropriate diagnosis codes, deny the claim and use the following EOMB or MSN message:

o EOMB 15.9, "The information we have in your case does not support the need for this service."

o MSN 15.4, "The information provided does not support the need for this service or item."

Use the following in the Remittance Message:

- o Claim adjustment reason code 50, "These are non-covered services because this is not deemed a medical necessity by the payer."

If a claim is denied because no evidence of a prior kidney transplant is presented, use the following EOMB or MSN message:

- o EOMB 15.9, "The information we have in your case does not support the need for this service."

- o MSN 15.4, "The information provided does not support the need for this service or item."

Use the following in the Remittance Message:

- o Claim adjustment reason code 50, "These are non-covered services because this is not deemed a medical necessity by the payer."

To further clarify the situation, the carrier should also use the new claim level remark code, MA126, "Pancreas transplant not covered unless kidney transplant performed."