

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12517	Date: February 22, 2024
	Change Request 13525

SUBJECT: Update of Internet Only Manual (IOM), Pub. 100-04, Chapter 8 - Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the title of chapter 8, section 50 and to update chapter 8, section 50.3 to insert existing condition codes related to home dialysis that were previously removed in error.

EFFECTIVE DATE: March 25,2024

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: March 25,2024

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	8/Table of Contents
R	8/50/Dialysis Bill Processing Procedures
R	8/50/50.3/Required Information for Claims Paid Under the End Stage Renal Disease Prospective Payment System ESRD PPS

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

**Business Requirements
Manual Instruction**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 12517	Date: February 22, 2024	Change Request: 13525
-------------	--------------------	-------------------------	-----------------------

SUBJECT: Update of Internet Only Manual (IOM), Pub. 100-04, Chapter 8 - Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims

EFFECTIVE DATE: March 25,2024

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: March 25,2024

I. GENERAL INFORMATION

A. Background: It has come to the attention of the Centers for Medicare & Medicaid Services (CMS) that condition codes 74 and 80 were inadvertently omitted from section 50.3 of the current version of the Internet Only Manual.

The purpose of this Change Request (CR) is to update the title of section 50 and to restore condition codes 74 and 80 to section 50.3.

B. Policy: There are no policy changes.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13525.1	Contractors shall be in compliance with the update to CMS Internet Only Manual (IOM) Pub. 100-04, Chapter 8 Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13525.2	Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it	X				

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Claims Processing Manual

Chapter 8 - Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims

Table of Contents
(Rev. 12517; Issued:02-22-24)

Transmittals for Chapter 8

50 - Dialysis Bill Processing Procedures

50.3 - Required Information for Claims Paid Under the End Stage Renal Disease Prospective Payment System (ESRD PPS)

50 - Dialysis Bill Processing Procedures

(Rev. 12517; Issued:02-22-24; Effective: 03-25-24; Implementation: 03-25-24)

General instructions for completing the claim are in Chapter 25. The following instructions apply to facility reporting of ESRD services and to A/B MAC (A) processing of in-facility dialysis claims.

The shared system checks the Common Working File (CWF) to determine if there is Employer Group Health Plan (EGHP) insurance. Where the beneficiary is covered under the EGHP insurance, see the Medicare Secondary Payer Manual.

50.3 - Required Information for Claims Paid Under the End Stage Renal Disease Prospective Payment System ESRD PPS

(Rev. 12517; Issued:02-22-24; Effective: 03-25-24; Implementation: 03-25-24)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

The electronic form required for billing ESRD claims is the ASC X12 837 institutional claim transaction. The paper form, where permissible, is Form CMS-1450.

The coding and related descriptions for the following items are identical for the ASC X12 837 institutional claim format and Form CMS-1450. See the related X12 implementation guide or Chapter 25, respectively, for where the information is reported.

Type of Bill

Acceptable codes for Medicare are:

721 - Admit Through Discharge Claim - This code is used for a bill encompassing an entire course of outpatient treatment for which the provider expects payment from the payer.

722 - Interim - First Claim - This code is used for the first of an expected series of payment bills for the same course of treatment.

723 - Interim - Continuing Claim - This code is used when a payment bill for the same course of treatment is submitted and further bills are expected to be submitted later.

724 - Interim - Last Claim - This code is used for a payment bill which is the last of a series for this course of treatment. The "Through" date of this bill (FL 6) is the discharge date for this course of treatment.

727 - Replacement of Prior Claim - This code is used when the provider wants to correct (other than late charges) a previously submitted bill. The previously submitted bill needs to be resubmitted in its entirety, changing only the items that need correction. This is the code used for the corrected or "new" bill.

728 - Void/Cancel of a Prior Claim - This code indicates this bill is a cancel-only adjustment of an incorrect bill previously submitted. Cancel-only adjustments should be used only in cases of incorrect provider identification numbers, incorrect Medicare beneficiary identifier, duplicate payments and some OIG

recoveries. For incorrect provider numbers or Medicare beneficiary identifier, a corrected bill is also submitted using a code 721.

Statement Covers Period (From-Through) - Hospital-based and independent renal dialysis facilities:

The beginning and ending service dates of the period included on this bill. Note: ESRD services are subject to the monthly billing requirements for repetitive services.

Condition Codes

Hospital-based and independent renal facilities complete these items. Note that one of the codes 71-76 is applicable for every bill. Special Program Indicator codes A0-A9 are not required.

Condition Code Structure (only codes affecting Medicare payment/processing are shown).

02 - Condition is Employment Related - Providers enter this code if the patient alleges that the medical condition causing this episode of care is due to environment/events resulting from employment.

04 - Information Only Bill - Providers enter this code to indicate the patient is a member of a Medicare Advantage plan.

59 – Non-Primary ESRD Facility – Providers enter this code to indicate that ESRD beneficiary received non-scheduled or emergency dialysis services at a facility other than his/her primary ESRD dialysis facility.

71 - Full Care in Unit - Providers enter this code to indicate the billing is for a patient who received staff-assisted dialysis services in a hospital or renal dialysis facility.

72 - Self-Care in Unit - Providers enter this code to indicate the billing is for a patient who managed his own dialysis in a hospital or renal dialysis facility.

73 - Self-Care in Training - Providers enter this code to indicate the billing is for special dialysis services where a patient and his/her helper (if necessary) were learning to perform dialysis.

74- Home-Providers enter this code to indicate the billing is for a patient who received dialysis services at home.

76 - Back-up In-facility Dialysis - Providers enter this code to indicate the billing is for a home dialysis patient who received back-up dialysis in a facility.

80- Home Dialysis-Nursing Facility – Home dialysis furnished in a SNF or Nursing Facility (report with condition code 74).

84 – Acute Kidney Injury- Provider enters this code to indicate the claim is for an AKI patient.

87 – Retraining – Provider enters this code to indicate the billing is for retraining of the patient and his/her helper (if necessary) to perform self-care dialysis.

H3 – Reoccurrence of GI Bleed comorbid category

H4 – Reoccurrence of Pneumonia comorbid category

H5 – Reoccurrence of Pericarditis comorbid Category

Occurrence Codes and Dates

Codes(s) and associated date(s) defining specific events(s) relating to this billing period are shown. Event codes are two alpha-numeric digits, and dates are shown as six numeric digits (MM-DD-YY). When occurrence codes 01-04 and 24 are entered, make sure the entry includes the appropriate value code, if there is another payer involved.

Occurrence and occurrence span codes are mutually exclusive. Occurrence codes have values from 01 through 69 and A0 through L9. Occurrence span codes have values from 70 through 99 and M0 through Z9.

24 - Date Insurance Denied - Code indicates the date of receipt of a denial of coverage by a higher priority payer.

33 - First Day of Medicare Coordination Period for ESRD Beneficiaries Covered by an EGHP - Code indicates the first day of the Medicare coordination period during which Medicare benefits are payable under an EGHP. This is required only for ESRD beneficiaries.

51 - Date of last Kt/V reading. For in-center hemodialysis patients, this is the date of the last reading taken during the billing period. For peritoneal dialysis patients and home hemodialysis patients, this date may be before the current billing period but should be within 4 months of the claim date of service.

Occurrence Span Code and Dates

Code(s) and associated beginning and ending dates(s) defining a specific event relating to this billing period are shown. Event codes are two alpha-numeric digits and dates are shown numerically as MM-DD-YY.

74 - Noncovered Level of Care - This code is used for repetitive Part B services to show a period of inpatient hospital care or of outpatient surgery during the billing period. Use of this code will not be necessary for ESRD claims with dates of service on or after April 1, 2007 due to the requirement of ESRD line item billing.

Document Control Number (DCN)

Required for all provider types on adjustment requests. (Bill Type/FL=XX7). All providers requesting an adjustment to a previous processed claim insert the DCN of the claims to be adjusted.

Value Codes and Amounts

Code(s) and related dollar amount(s) identify monetary data that are necessary for the processing of this claim. The codes are two alphanumeric digits and each value allows up to nine numeric digits (000000.00). Negative amounts are not allowed. Whole numbers or non-dollar amounts are right justified to the left of the dollars and cents delimiter. Some values are reported as cents, so refer to specific codes for instructions. If more than one value code is shown for a billing period, show the codes in ascending alphanumeric sequence.

Value Code Structure (Only codes used to bill Medicare are shown.):

06 - Medicare Blood Deductible - Code indicates the amount the patient paid for un-replaced deductible blood.

13 - ESRD Beneficiary in the 30- Month Coordination Period with an EGHP - Code indicates that the amount shown is that portion of a higher priority EGHP payment on behalf of an ESRD beneficiary that applies to covered Medicare charges on this bill. If the provider enters six zeros (0000.00) in the amount field, it is claiming a conditional payment because the EGHP has denied coverage or there has been a substantial delay in its payment. Where the provider received no payment or a reduced payment because of failure to file a proper claim, this is the amount that would have been payable had it filed a proper claim.

17 – Not submitted by the provider. The Medicare shared system will display this payer only code on the claim when an outlier payment is being made. The value is the total claim outlier payment.

19 – Not submitted by the provider. The Medicare shared system will display this payer only code on the claim for low volume providers to identify the amount of the low volume adjustment being included in the provider's reimbursement.

37 - Pints of Blood Furnished - Code indicates the total number of pints of blood or units of packed red cells furnished, whether or not replaced. Blood is reported only in terms of complete pints rounded upwards, e.g., 1 1/4 pints is shown as 2 pints. This entry serves a basis for counting pints towards the blood deductible. Hospital-based and independent renal facilities must complete this item.

38 - Blood Deductible Pints - Code indicates the number of un-replaced deductible pints of blood supplied. If all deductible pints furnished have been replaced, no entry is made. Hospital-based and independent renal facilities must complete this item.

39 - Pints of Blood Replaced - Code indicates the total number of pints of blood donated on the patient's behalf. Where one pint is donated, one pint is replaced. If arrangements have been made for replacement, pints are shown as replaced. Where the provider charges only for the blood processing and administration, i.e., it does not charge a "replacement deposit fee" for un-replaced pints, the blood is considered replaced for purposes of this item. In such cases, all blood charges are shown under the 039x revenue code series, Blood Administration. Hospital-based and independent renal facilities must complete this item.

44 - Amount Provider Agreed To Accept From Primary Payer When This Amount is Less Than Charges But Higher than Payment Received - Code indicates the amount shown is the amount the provider was obligated or required to accept from a primary payer as payment in full when that amount is less than the charges but higher than amount actually received. A Medicare secondary payment is due.

47 - Any Liability Insurance - Code indicates amount shown is that portion from a higher priority liability insurance made on behalf of a Medicare beneficiary that the provider is applying to Medicare covered services on this bill. If six zeros (0000.00) are entered in the amount field, the provider is claiming conditional payment because there has been substantial delay in the other payer's payment.

48 - Hemoglobin Reading - Code indicates the most recent hemoglobin reading taken before the start of this billing period. This is usually reported in three positions with a decimal. Use the right of the delimiter for the third digit. The blood sample for the hemoglobin reading must be obtained before the dialysis treatment. If a hemoglobin value is not available facilities must report the value 99.99.

49 - Hematocrit Reading - Code indicates the most recent hematocrit reading taken before the start of this billing period. This is usually reported in two positions (a percentage) to the left of the dollar/cents delimiter. If the reading is provided with a decimal, use the position to the right of the delimiter for the third digit. The blood sample for the hemoglobin reading must be obtained before the dialysis treatment. If a hematocrit value is not available facilities must report the value 99.99

71 - Funding of ESRD Networks - Code indicates the amount of Medicare payment reduction to help fund the ESRD networks. This amount is calculated by the A/B MAC (A) and forwarded to CWF. (See §120 for discussion of ESRD networks).

79 – Not submitted by the provider. The Medicare shared system will display this payer only code on the claim. The value represents the dollar amount for Medicare allowed payments applicable for the calculation in determining an outlier payment.

A8 – Weight of Patient – Code indicates the weight of the patient in kilograms. The weight of the patient should be measured after the last dialysis session of the month.

A9 – Height of Patient – Code indicates the height of the patient in centimeters. The height of the patient should be measured during the last dialysis session of the month. The measurement is required no less frequently than once per year but must be reported on every claim. This height is as the patient presents.

D5 – Result of last Kt/V reading. For in-center hemodialysis patients this is the last reading taken during the billing period. For peritoneal dialysis patients and home hemodialysis this may be before the current billing period but should be within 4 months of the claim date of service.

Q8 – Not submitted by the provider. The Medicare shared system will display this payer only code on the claim. The value represents the dollar amount for the services applicable to the calculation of the transitional drug add-on adjustment (TDAPA).

QG – Not submitted by the provider. The Medicare shared system will display this payer only code on the claim. The value represents the dollar amount for the services applicable to the calculation of the new innovative equipment and supplies add-on adjustment (TPNIES).

Revenue Codes

The revenue code for the appropriate treatment modality is billed (e.g., 0821 for hemodialysis). Effective January 1, 2015, ESRD facilities are required to report on the claim the drugs identified on the consolidated billing list provided at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Consolidated_Billing.html

082X - Hemodialysis - Outpatient or Home Dialysis - A waste removal process performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed directly from the blood. Detailed revenue coding is required. Therefore, services may not be summed at the zero level.

0 - General Classification	HEMO/OP OR HOME
1 – Hemodialysis/Composite or other rate	HEMO/COMPOSITE
2 - Home Supplies	HEMO/HOME/SUPPL
3 - Home Equipment	HEMO/HOME/EQUIP
4 - Maintenance 100%	HEMO/HOME/100%
5 - Support Services	HEMO/HOME/SUPSERV
9 - Other Hemodialysis Outpatient	HEMO/HOME/OTHER

083X - Peritoneal Dialysis - Outpatient or Home - A waste removal process performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed indirectly by instilling a special solution into the abdomen using the peritoneal membrane as a filter.

0 - General Classification	PERITONEAL/OP OR HOME
1 - Peritoneal/Composite or other rate	PERTNL/COMPOSITE
2 - Home Supplies	PERTNL/HOME/SUPPL
3 - Home Equipment	PERTNL/HOME/EQUIP
4 - Maintenance 100%	PERTNL/HOME/100%
5 - Support Services	PERTNL/HOME/SUPSERV
9 -Other Peritoneal Dialysis	PERTNL/HOME/OTHER

084X - Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient - A continuous dialysis process performed in an outpatient or home setting, which uses the patient's peritoneal membrane as a dialyzer.

0 - General Classification	CAPD/OP OR HOME
1 - CAPD/Composite or other rate	CAPD/COMPOSITE
2 - Home Supplies	CAPD/HOME/SUPPL
3 - Home Equipment	CAPD/HOME/EQUIP
4 - Maintenance 100%	CAPD/HOME/100%

5 - Support Services	CAPD/HOME/SUPSERV
9 -Other CAPD Dialysis	CAPD/HOME/OTHER

085X - Continuous Cycling Peritoneal Dialysis (CCPD) - Outpatient. - A continuous dialysis process performed in an outpatient or home setting, which uses the patient's peritoneal membrane as a dialyzer.

0 - General Classification	CCPD/OP OR HOME
1 - CCPD/Composite or other rate	CCPD/COMPOSITE
2 - Home Supplies	CCPD/HOME/SUPPL
3 - Home Equipment	CCPD/HOME/EQUIP
4 - Maintenance 100%	CCPD/HOME/100%
5 - Support Services	CCPD/HOME/SUPSERV
9 -Other CCPD Dialysis	CCPD/HOME/OTHER

088X - Miscellaneous Dialysis - Charges for Dialysis services not identified elsewhere.

0 - General Classification	DAILY/MISC
1 - Ultrafiltration	DAILY/ULTRAFILT
2 - Home dialysis aid visit	HOME DIALYSIS AID VISIT
9 -Other misc. Dialysis	DAILY/MISC/OTHER

HCPCS/Rates

All ESRD hemodialysis claims must include HCPCS 90999 on the line reporting revenue code 082x. All AKI claims must include HCPCS G0491.

Modifiers

Modifiers are required with ESRD Billing for reporting the adequacy of dialysis and the vascular access. For information on modifiers required for these quality measures see 50.9 of this chapter.

For information on reporting modifiers applicable to the Erythropoietin Stimulating Agents refer to section 60.4 of this chapter.

Route of administration modifiers required are JA, JB and JE.

For information on reporting the AY modifier for services not related to the treatment of ESRD, see sections 60.2.1.1 - Separately Billable ESRD Drugs and 60.1 - Lab Services.

For information on reporting the CG modifier for additional treatments provided without medical justification, see section 10.1 of this chapter.

Service Date

Report the line item date of service for each dialysis session and each separately payable item or service.

Service Units

Hospital-based and independent renal facilities must complete this item. The entries quantify services by revenue category, e.g., number of dialysis treatments. Units are defined as follows:

0634 - Erythropoietin (EPO) - Administrations, i.e., the number of times an injection of less than 10,000 units of EPO was administered. For claims with dates of service on or after January 1, 2008, facilities use the units field as a multiplier of the dosage description in the HCPCS to arrive at the dosage amount per administration.

0635 - Erythropoietin (EPO) - Administrations, i.e., the number of times an injection of 10,000 units or more of EPO was administered. For claims with dates of service on or after January 1, 2008, facilities use the units field as a multiplier of the dosage description in the HCPCS to arrive at the dosage amount per administration.

082X - (Hemodialysis) - Sessions

083X - (Peritoneal) - Sessions

084X - (CAPD) – Per Day

085X - (CCPD) – Per Day

Effective April 1, 2007, the implementation of ESRD line item billing requires that each dialysis session be billed on a separate line. As a result, claims with dates of service on or after April 1, 2007 should not report units greater than 1 for each dialysis revenue code line billed on the claim.

Total Charges

Hospital-based and independent renal facilities must complete this item. Hospital-based facilities must show their customary charges that correspond to the appropriate revenue code. They must not enter their composite or the EPO` rate as their charge. Independent facilities may enter their composite and/or EPO rates.

Neither revenue codes nor charges for services included in the composite rate may be billed separately (see §90.3 for a description). Hospitals must maintain a log of these charges in their records for cost apportionment purposes.

Services which are provided but which are not included in the composite rate may be billed as described in sections that address those specific services.

The last revenue code entered in as 0001 represents the total of all charges billed.

Principal Diagnosis Code

Hospital-based and independent renal facilities must complete this item and it should include a diagnosis of end stage renal disease for patients with ESRD. For patients with AKI see section 40 of this chapter.

Other Diagnosis Code(s)

For claims with dates of service on or after January 1, 2011 renal dialysis facilities report the appropriate diagnosis code(s) for comorbidity conditions eligible for an adjustment.