THE NATIONAL FORUM OF ESRD NETWORKS

FORUM OF END STAGE RENAL DISEASE NETWORKS

PRESS RELEASE

Medicare Billing for Outpatient Dialysis in the Hospital Setting

[Birchwood WI; April 10, 2019]

Currently, there seems to be a lack of knowledge, and inconsistency about how to best provide dialysis to outpatients who are being seen in an acute care hospital but also require dialysis before they are discharged from the facility. Some examples of when this situation occurs include: after an outpatient vascular access procedure is performed in the hospital, or when the patient is seen in the Emergency Department for fluid overload or hyperkalemia and requires "outpatient" dialysis. In many cases these patients may be in the hospital-based access center or Emergency Department and therefore, miss their usual outpatient dialysis. At other times, the outpatient dialysis unit might be closed or lacks an open slot to accommodate the patient's immediate and unscheduled dialysis needs.

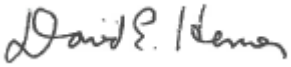
Many hospitals are unaware of the CMS policy regarding the provision of outpatient dialysis in the hospital setting and how to bill for it properly. Often, the nephrologist and perhaps the ED physician are told, or have as part of their "urban lore", that the patient must be admitted to the hospital in order to be able to provide a single dialysis treatment prior to subsequent discharge.

This perception of CMS policy is incorrect for several reasons:

1. Since 2000 according to the CMS Claims Processing Manual (website and applicable text attached), CMS has said that they will pay for outpatient dialysis at a hospital if the patient is at the hospital for another reason, e.g., emergency care in the Emergency Department, a vascular access procedure, or a transfusion necessitating dialysis. The HCPCS code is G0257.
2. Since the patient did not stay for two midnights, the "admission" must be considered observation (or bedded outpatient), and the hospital must also bill for observation. Under observation status, the Nephrologist cannot bill for inpatient dialysis. Furthermore, if the patient is admitted as a full admission or as a bedded outpatient on observation status, the physician will need to perform a full History and Physical, discharge summary, and admission and discharge orders, all in an effort to perform an outpatient dialysis treatment. Despite all this extra work, the Nephrologist and the hospital will both likely not be reimbursed by Medicare, because CMS considers such situations adequately covered by the attached CMS policy.

Many members on the Forum of ESRD Networks Medical Advisory Council (MAC) were unaware of this CMS policy enabling outpatient dialysis to be performed during an acute care episode in the hospital. We therefore felt it would be appropriate to disseminate this information to all Networks and we encourage Networks to share this information to nephrologists and hospitals that perform dialysis in their state(s). We would encourage communications to hospitals to be sent to the offices of the Chief Financial Officers, alerting them that they are likely not getting paid correctly for this service because they may not be billing correctly and to the Chief Medical Officer to ensure that opportunities for avoiding an admission are vigorously utilized.

Communications to Nephrologists should alert the physicians that they do not have to admit patients to the hospital and generate elaborate documentation simply to provide an outpatient dialysis treatment. Instead, for outpatient dialysis suitable patients, Nephrologists should only order dialysis and document a dialysis visit, and bill as a non-comprehensive MCP, regular visit.



David Henner, DO
Chair, Medical Advisory Council
National Forum of ESRD Networks

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf

Medicare Claims Processing Manual
Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)
(Rev. 4233, 02-08-19)

200.2 - Hospital Dialysis Services For Patients With and Without End Stage Renal Disease (ESRD)
(Rev. 2455, Issued: 04-26-12, Effective: 10-01-12, Implementation; 10-01-12)

Effective with claims with dates of service on or after August 1, 2000, hospital-based End Stage Renal Disease (ESRD) facilities must submit services covered under the ESRD benefit in 42 CFR 413.174 (maintenance dialysis and those items and services directly related to dialysis such as drugs, supplies) on a separate claim from services not covered under the ESRD benefit. Items and services not covered under the ESRD benefit must be billed by the hospital using the hospital bill type and be paid under the Outpatient Prospective Payment System (OPPS) (or to a CAH at reasonable cost). Services covered under the ESRD benefit in 42 CFR 413.174 must be billed on the ESRD bill type and must be paid under the ESRD PPS. This requirement is necessary to properly pay only unrelated ESRD services (those not covered under the ESRD benefit) under OPPS (or to a CAH at reasonable cost).

Medicare does not allow payment for routine or related dialysis treatments, which are covered and paid under the ESRD PPS, when furnished to ESRD patients in the outpatient department of a hospital. However, in certain medical situations in which the ESRD outpatient cannot obtain her or his regularly scheduled dialysis treatment at a certified ESRD facility, the OPPS rule for 2003 allows payment for non-routine dialysis treatments (which are not covered under the ESRD benefit) furnished to ESRD outpatients in the outpatient department of a hospital. Payment for unscheduled dialysis furnished to ESRD outpatients and paid under the OPPS is limited to the following circumstances:

- Dialysis performed following or in connection with a dialysis-related procedure such as vascular access procedure or blood transfusions;
- Dialysis performed following treatment for an unrelated medical emergency; e.g., if a patient goes to the emergency room for chest pains and misses a regularly scheduled dialysis treatment that cannot be rescheduled, CMS allows the hospital to provide and bill Medicare for the dialysis treatment; or
- Emergency dialysis for ESRD patients who would otherwise have to be admitted as inpatients in order for the hospital to receive payment.

In these situations, non-ESRD certified hospital outpatient facilities are to bill Medicare using the Healthcare Common Procedure Coding System (HCPCS) code G0257 (Unscheduled or emergency dialysis treatment for an ESRD patient in a hospital outpatient department that is not certified as an ESRD facility).

HCPCS code G0257 may only be reported on type of bill 13X (hospital outpatient service) or type of bill 85X (critical access hospital) because HCPCS code G0257 only reports services for hospital outpatients with ESRD and only these bill types are used to report services to hospital outpatients. Effective for services on and after October 1, 2012, claims containing HCPCS code G0257 will be returned to the provider for correction if G0257 is reported with a type of bill other than 13X or 85X (such as a 12x inpatient claim).

HCPCS code 90935 (Hemodialysis procedure with single physician evaluation) may be reported and paid only if one of the following two conditions is met:

1) The patient is a hospital inpatient with or without ESRD and has no coverage under Part A, but has Part B coverage. The charge for hemodialysis is a charge for the use of a prosthetic device. See Benefits Policy Manual 100-02 Chapter 15 section 120. A. The service must be reported on a type of bill 12X or type of bill 85X. See the Benefits Policy Manual 100-02 Chapter 6 section 10 (Medical and Other Health Services Furnished to Inpatients of Participating Hospitals) for the criteria that must be met for services to be paid when a hospital inpatient has Part B coverage but does not have coverage under Part A; or

2) A hospital outpatient does not have ESRD and is receiving hemodialysis in the hospital outpatient department. The service is reported on a type of bill 13X or type of bill 85X.

CPT code 90945 (Dialysis procedure other than hemodialysis (e.g. peritoneal dialysis, hemofiltration, or other continuous replacement therapies)), with single physician evaluation, may be reported by a hospital paid under the OPPS or CAH method I or method II on type of bill 12X, 13X or 85X.