CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1876	**Date: DECEMBER 18, 2009**
	Change Request 6557

SUBJECT: Coverage of Kidney Disease Patient Education Services

I. SUMMARY OF CHANGES: MIPPA Section 152(b) adds Kidney Disease Patient Education services as a Medicare covered benefit for Medicare beneficiaries diagnosed with Stage IV chronic kidney disease (CKD). The services are designed to provide beneficiaries with comprehensive information regarding the management of comorbidities, including for purposes of delaying the need for dialysis; prevention of uremic complications; and each option for renal replacement therapy. The benefit is also designed to be tailored to individual needs and provide the beneficiary with the opportunity to actively participate in his/her choice of therapy.

New / Revised Material
Effective Date: January 1, 2010
Implementation Date: April 5, 2010

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

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	5/100/100.1.1/Allowable Revenue Codes on CORF 75X Bill Types
R	32/Table of Contents
N	32/20/Billing Requirements for Coverage of Kidney Disease Patient Education Services
N	32/20/20.1/Additional Billing Requirements Applicable to Claims Submitted to Fiscal Intermediaries (FIs)
N	32/20/20.2/Healthcare Common Procedure Coding System (HCPCS) Procedure Codes and Applicable Diagnosis Codes
N	32/20/20.3/Medicare Summary Notices (MSNs) and Claim Adjustment Reason Codes (CARCs)
N	32/20/20.4/Advanced Beneficiary Notice (ABN) Information

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: 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

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

Attachment – Business Requirements

Pub. 100-04	Transmittal: 1876	Date: December 18,2009	Change Request: 6557

SUBJECT: Coverage of Kidney Disease Patient Education Services

Effective Date: January 1, 2010
Implementation Date: April 5, 2010

I. GENERAL INFORMATION

A. Background: By definition, chronic kidney disease (CKD) is kidney damage for 3 months or longer, regardless of the cause of kidney damage. CKD typically evolves over a long period of time and patients may not have symptoms until significant, possibly irreversible, damage has been done. Complications can develop from kidneys that do not function properly, such as high blood pressure, anemia, and weak bones. When chronic kidney disease progresses, it may lead to kidney failure, which requires artificial means to perform kidney functions (dialysis) or a kidney transplant to maintain life.

Patients can be classified into 5 stages of CKD, based on how quickly blood is filtered through the kidneys (glomerular filtration rate, or GFR), with stage I having kidney damage with normal or increased GFR to stage V with kidney failure, also called end-stage renal disease (ESRD). Once patients with CKD are identified, treatment is available to help prevent complications of decreased kidney function, slow the progression of kidney disease, and reduce the risk of other diseases such as heart disease.

Individuals with CKD may benefit from kidney disease education (KDE) interventions due to the large amount of medical information that could affect patient outcomes, including the increasing emphasis on self-care and patients' desire for informed, autonomous decision-making. Pre-dialysis education can help patients achieve better understanding of their illness, dialysis modality options, and may help delay the need for dialysis. Education interventions should be patient-centered, encourage collaboration, offer support to the patient, and be delivered consistently.

B. Policy: Section 152(b) of the Medicare Improvements for Patients and Providers Act (MIPPA) added KDE services as a Medicare Part B covered benefit for Medicare beneficiaries diagnosed with Stage IV CKD (severe decrease in GFR; GFR value of 15-29 ml/min/1.73 m^2), who have received a referral from the physician managing the beneficiary's kidney condition. The Centers for Medicare & Medicaid Services (CMS) published regulations implementing this provision at 42 CFR 410.48. KDE services will be tailored to meet the needs of the individual beneficiary involved, designed to provide beneficiaries opportunities to actively participate in the choice of therapy, and provide comprehensive information regarding:

- Management of comorbidities, including for the purpose of delaying the need for dialysis;
- Prevention of uremic complications; and
- Each option for renal replacement therapy (including hemodialysis and peritoneal dialysis, at home and in-facility, dialysis access options, and transplantation);

Contractors will pay for KDE services that meet the following conditions:

- No more than 6 sessions of KDE services are provided in a beneficiary's lifetime,

- Sessions billed in increments of 1 hour (In order to bill for a session, a session must be at least 31 minutes in duration. A session that lasts at least 31 minutes, but less than 1 hour still constitutes 1 session.),
- Sessions furnished either individually or in a group setting of 2 to 20 individuals, that need not all be Medicare beneficiaries, and
- Furnished, upon the referral of the physician managing the beneficiary's kidney condition, by a qualified person meaning a:

    - physician, physician's assistant, nurse practitioner, or clinical nurse specialist;
    - hospital, critical access hospital (CAH), comprehensive outpatient rehabilitation facility (CORF), home health agency (HHA), or hospice, that is located in a rural area; or
    - hospital or CAH that is paid as if it were located in a rural area (hospitals and CAHs reclassified as rural under section 42 CFR 412.103).

NOTES:

- In section 42 CFR 485.610(b), a CAH (TOB 85X) is a rural provider. Therefore, a CAH is designated as a qualified person for purposes of furnishing KDE services irrespective of the provider's geographic location.

- Renal dialysis facilities (TOB 72X) are precluded from providing KDE services irrespective of the provider's geographic location.

CMS will issue 2 new HCPCS codes to be used to report covered KDE services in the January 2010 IOCE and the Medicare Physician Fee Schedule Database (MPFSDB). CMS will identify the payment amounts in the final 2010 Medicare Physician Fee Schedule (MPFS).

G0420: Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per one hour

G0421: Face-to-face educational services related to the care of chronic kidney disease; group, per session, per one hour

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6557.1	Effective for claims with dates of service on and after January 1, 2010, contractors shall pay claims for KDE services when provided to patients with stage IV CKD subject to criteria in Pub 100-02, Medicare Benefit Policy Manual, chapter 15, section 310 and Pub 100-04, Medicare Claims Processing Manual, chapter 32, section 20.	X		X	X	X	X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6557.2	Contractors shall pay claims for KDE services containing HCPCS codes G0420 or G0421 with ICD-9 diagnosis code 585.4 (chronic kidney disease, Stage IV (severe)).	X		X	X	X	X				Jan. 2010 MPFSDB, Jan 2010 IOCE
6557.2.1	Contractors shall pay claims for KDE services containing HCPCS codes G0420 or G0421 on TOBs 12X, 13X, 22X, 23X, 34X, 75X, 81X, 82X and 85X under the MPFS.	X		X		X	X				
6557.2.2	Contractors shall deny claims for KDE services billed without diagnosis code 585.4 and use the following messages: MSN 16.10 Medicare does not pay for this item or service. Spanish Version: "Medicare no paga por este artículo o servicio." CARC 167 – This (these) diagnosis(es) is (are) not covered.	X		X	X	X	X				
6557.3	Effective for claims with dates of service on or after January 1, 2010, CWF shall create a line item edit to ensure that claims with HCPCS G0420 or G0421 with ICD-9 585.4 billed for KDE services are not allowed on both a professional and institutional claim on the same service date. **NOTE:** CWF shall allow contractors to override the edit if the denial is overturned on appeal.	X			X		X			X	
6557.3.1	Contractors shall deny subsequent claims for KDE services if two claims are billed (professional and institutional) on the same service date. Use the following messages: MSN 15.5 – The information provided does not support the need for similar services by more than one doctor during the same time period. Spanish Version: "La información proporcionada no confirma la necesidad por servicios similares por más de un médico durante el mismo periodo."	X		X	X	X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	CARC – 18 – Duplicate claim/service.										
6557.4	Effective for claims with dates of service on or after January 1, 2010, CWF shall create an edit to allow no more than 6 sessions of KDE services, HCPCS G0420 or G0421 with ICD-9 585.4, in a beneficiary's lifetime.	X			X		X			X	
6557.4.1	Contractors shall deny claims containing HCPCS G0420 or G0421 with ICD-9 585.4, for KDE services when submitted for more than 6 sessions, using the following messages: MSN 15.22 - The information provided does not support the need for this many services or items in this period of time so Medicare will not pay for this item or service. Spanish Version: "La información proporcionada no justifica la necesidad de esta cantidad de servicios o artículos en este periodo de tiempo por lo cual Medicare no pagará por este artículo o servicio." CARC 119 - Benefit maximum for this time period or occurrence has been reached.	X		X	X	X					
6557.5	Contractors shall pay for KDE services submitted on one of the following Type Of Bills (TOBs): 12X, 13X, 22X, 23X, 34X, 75X, 81X and 82X only when received from a provider located in a rural area.	X		X		X	X				
6557.5.1	Contractors shall pay for KDE services when TOB 85X is received irrespective of the provider's geographic classification.	X		X			X				
6557.5.2	Contractors shall pay for KDE services when the above TOBs are received from a section 401 hospital (i.e., the provider is found on the annually updated Table 9C of the IPPS Rule. See attachment A.).	X		X		X	X				
6557.6	Contractors shall only allow HCPCS codes G0420 and G0421 with ICD-9 code 585.4, to be billed with revenue code 0942 on the following TOBs: 22X, 23X, 34X, 75X, 81X, 82X and 85X.	X		X		X	X				
6557.6.1	Contractors shall update the revenue code file	X				X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	to allow hospice claims to bill for revenue code 0942.										
6557.6.1.1	Contractors shall return to the provider any hospice claims billing for revenue code 0942 when other services are also included on the claim.	X				X	X				
6557.6.1.2	CWF shall ensure that the hospice benefit period is not updated from hospice claims billing for KDE services.									X	
6557.6.1.3	Contractors shall ensure that hospice claims billed for 0942 are paid from the Part B Trust Fund.						X				
6557.6.1.4	Contractors shall ensure that hospice claims, TOBs 81X and 82X, contain value code 61 or G8 when billing for KDE services, HCPCS codes G0420 and G0421.	X		X			X				
6557.7	Contractors shall deny payment for KDE services when rendered in an urban area unless the provider is a 401 hospital (see 6557.5.2), or submits on TOB 85X.	X		X		X	X				
6557.7.1	Contractors shall use the following messages when denying KDE services: MSN 21.6 - This item or service is not covered when performed, referred or ordered by this provider. Spanish Version: "Este servicio no está cubierto cuando es rendido, referido u ordenado por este proveedor." CARC 170 - Payment is denied when performed/billed by this type of provider.	X		X		X					
6557.8	Contractors shall pay for KDE services for hospitals in Maryland under the jurisdiction of the Health Services Cost Review Commission (HSCRC), TOBs 12X or 13X, on an inpatient Part B or outpatient basis in accordance with the terms of the Maryland Waiver.	X		X	X		X				
6557.9	Contractors shall not search their files for claims with dates of service between January 1, 2010, and the implementation of this CR. However, contractors may adjust claims brought to their attention.	X		X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6557.10	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X	X	X					

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
6557.5	Rural providers can be identified through a rural CBSA on the Provider Specific File (i.e., _ _ _16) or through a rural designation on the Medicare ZIP Code File.
6557.5.2	Table 9C can be found in the "Wage Index Files" of the Acute Inpatient PPS. See Attachment A.
6557.2.2 6557.3.1 6557.4.1 6557.7.1	If an advanced beneficiary notice (ABN) is provided with a GA modifier indicating there is a signed ABN on file, contractors shall use Group Code PR (Patient Responsibility) and the liability falls to the beneficiary. If an ABN is provided with a GZ modifier indicating no ABN was provided, contractors shall use Group Code CO (Contractual Obligation) and the liability falls to the provider.

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s):
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William Ruiz, 410-786-9283, william.ruiz@cms.hhs.gov (institutional claims processing).

Post-Implementation Contact(s): CMS Regional Offices

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *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.

Attachment

Attachment A

TABLE 9C.--HOSPITALS REDESIGNATED AS RURAL UNDER SECTION 1886(d)(8)(E) OF THE ACT - FY 2010		
Provider No.	**Geographic CBSA**	**Redesignated Rural Area**
040118	27860	04
050192	23420	05
050528	32900	05
050618	40140	05
070004	07	07
100048	37860	10
100118	37380	10
100134	27260	10
140167	14	14
170137	29940	17
180038	36980	18
220051	38340	22
230078	35660	23
250017	25	25
260006	41140	26
260034	28140	26
260047	27620	26
260195	44180	26
300023	40484	33
330235	33	33
330268	10580	33
340010	24140	34
360125	36	36
370054	36420	37
380040	13460	38
390130	27780	39
390183	39	39
390233	49620	39
450052	45	45
450078	10180	45
450243	10180	45
450348	45	45
490116	13980	49
500148	48300	50

100.1.1 - Allowable Revenue Codes on CORF 75X Bill Types

(Rev. 1876; Issued: 12-18-09; Effective Date: 01-01-10; Implementation Date: 04-05-10)

Effective July 1, 2008, the following revenue codes are allowable for reporting CORF services on 75X bill types:

0270	0274	0279	0410
0412	0419	042X	043X
044X	0550	0559	0560
0569	0636	0771	0900
0911	0914	0919	*0942*

NOTE: Billed revenue codes not listed in the above list will be returned to the provider by Medicare systems. See Chapter 25, Completing and Processing the CMS-1450 Data Set, for revenue code descriptions.

Medicare Claims Processing Manual
Chapter 32 - Billing Requirements for Special Services

Table of Contents
(Rev. 1876, 12-18-09)

20 – Billing Requirements for Coverage of Kidney Disease Patient Education Services

(Rev. 1876; Issued: 12-18-09; Effective Date: 01-01-10; Implementation Date: 04-05-10)

Effective for claims with dates of service on and after January 1, 2010, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) determines that kidney disease patient education services are covered when provided to patients with stage IV chronic kidney disease (CKD). See Pub. 100-02, chapter 15, section 310, for complete coverage guidelines.

Contractors shall pay for kidney disease education (KDE) services that meet the following conditions:

- *No more than 6 sessions of KDE services are provided in a lifetime,*
- *Is provided in increments of 1 hour. In order to bill for a session, a session must be at least 31 minutes in duration. A session that lasts at least 31 minutes, but less than 1 hour still constitutes 1 session.*
- *Is provided either individually or in a group setting of 2 to 20 individuals who need not all be Medicare beneficiaries.*
- *Furnished, upon the referral of the physician managing the beneficiary's kidney condition, by a qualified person meaning a:*
    - *physician, physician's assistant, nurse practitioner, or clinical nurse specialist;*
    - *hospital, critical access hospital (CAH), skilled nursing facility (SNF), comprehensive outpatient rehabilitation facility (CORF), home health agency (HHA), or hospice, that is located in a rural area, or*
    - *hospital or CAH that is paid as if it were located in a rural area (hospital or CAH reclassified as rural under section 42 CFR 412.103).*

NOTE: *A renal dialysis facility (Type of Bill (TOB) 72x) is precluded from providing KDE services.*

20.1 – Additional Billing Requirements Applicable to Claims Submitted to Fiscal Intermediaries (FIs)

(Rev. 1876; Issued: 12-18-09; Effective Date: 01-01-10; Implementation Date: 04-05-10)

The FI will reimburse for KDE services when services are rendered in a rural area and submitted on the following TOBs: 12X, 13X, 22X, 23X, 34X, 75X, 81X, 82X, and 85X.

NOTE: *FIs shall use the actual geographic location, core based statistical area (CBSA) to identify facilities located in rural areas. In addition, KDE services are covered when claims containing the above mentioned TOBs are received from section 401 hospitals.*

Revenue code 0942 should be reported when billing for KDE services in the following: SNFs, HHAs, CORFs, hospices, and CAHs.

Hospital outpatient departments bill for this service under any valid/appropriate revenue code. They are not required to report revenue code 0942.

Hospices report this service on a separate claim from any hospice services. Hospice claims billed for revenue code 0942 that contain any other services will be returned to the provider. In addition, hospices report value code 61 or G8 when billing for KDE services.

NOTE: *KDE services are not covered when services are submitted on TOB 72X.*

20.2 - Healthcare Common Procedure Coding System (HCPCS) Procedure Codes and Applicable Diagnosis Codes

(Rev. 1876; Issued: 12-18-09; Effective Date: 01-01-10; Implementation Date: 04-05-10)

Effective for services performed on and after January 1, 2010, the following new HCPCS codes have been created for KDE services when provided to patients with stage IV CKD.

- *G0420: Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per one hour*

- *G0421: Face-to-face educational services related to the care of chronic kidney disease; group, per session, per one hour*

The following diagnosis code should be reported when billing for KDE services:

- *585.4 (chronic kidney disease, Stage IV (severe)).*

NOTE*: Claims with HCPCS codes G0420 or G0421 and ICD-9 code 585.4 that are billed for KDE services are not allowed on a professional and institutional claim on the same service date.*

20.3 - Medicare Summary Notices (MSNs) and Claim Adjustment Reason Codes (CARCs)

(Rev. 1876; Issued: 12-18-09; Effective Date: 01-01-10; Implementation Date: 04-05-10)

The following messages are used by Medicare contractors when denying non-covered services associated with KDE services when provided to patients with stage IV CKD:

When denying claims for KDE services billed without diagnosis code 585.4 contractors shall use:

- *MSN 16.10 - Medicare does not pay for this item or service.*
- *CARC 167 - This (these) diagnosis(es) is (are) not covered.*

When denying claims for KDE services when submitted for more than 6 sessions contractors shall use:

- *MSN 15.22 - The information provided does not support the need for this many services or items in this period of time so Medicare will not pay for this item or service.*
- *CARC 119 - Benefit maximum for this time period or occurrence has been reached.*

When denying claims for KDE services when two claims are billed (professional and institutional) on the same service date, contractors shall use:

- *MSN 15.5 – The information provided does not support the need for similar services by more than one doctor during the same time period.*
- *CARC 18 – Duplicate claim/service.*

FIs shall deny KDE services when rendered in an urban area unless:

- *The provider is a hospital on the section 401 list or*
- *The claim is submitted on TOB 85X.*

FIs shall deny payment for KDE services when submitted on TOB 72X.
Use the following messages:

- *MSN 21.6 – This item or service is not covered when performed, referred or ordered by this provider.*
- *CARC 170 – Payment is denied when performed/billed by this type of provider.*

20.4 - Advance Beneficiary Notice (ABN) Information

(Rev. 1876; Issued: 12-18-09; Effective Date: 01-01-10; Implementation Date: 04-05-10)

If a signed ABN was provided, contractors shall use Group Code PR (Patient Responsibility) and the liability falls to the beneficiary.

If an ABN was not provided, contractors shall use Group Code CO (Contractual Obligation) and the liability falls to the provider.