Internal Medicine Coding Alert

Get Paid for Supervision of Dialysis Patients

Internal medicine physicians and nephrology subspecialists who supervise end-stage renal disease (ESRD) patients on hemodialysis must be careful to accurately report services included in the monthly capitated payment (MCP), and break out services not included, to receive appropriate reimbursement without overbilling third-party payers.

Anything pertaining to end-stage renal disease, the outpatient dialysis treatment and all of the services provided by the physician are included in the monthly payment, explains **Ann Brooks,** office manager for the Greenville Kidney Center, in Greenville, S.C. Even if the patient is seen in the office during the month for a visit related to ESRD or to a complication from dialysis, that visit is included in the capitated payment and cannot be reported separately, she adds.

Most payers, including Medicare, reimburse supervision of dialysis patients on a set, monthly capitated rate. The physician reports one code at the end of the full-month during which services are provided. If the supervision is not provided for the entire month, other codes for individual days of supervision are used, Brooks says.

According to Empire Medicare Services, the Medicare Part B contractor for New York and New Jersey, the codes used for hemodialysis are:

90918-90921end-stage renal disease (ESRD) related services per full month; for specified age groups;
90922-90925end-stage renal disease (ESRD) related services (less than full month), per day; for specified age groups;
90935 and 90937hemodialysis procedures;
90945 and 90947dialysis procedures;
90989 and 90993dialysis training, patient; and
90997hemoperfusion.

Successfully Billing Per Month

In most situations, the physician will report one of the codes between 90918 and 90921 based on the age of the patient.

Basically, the patients hemodialyze three days a week, three to four hours at a time at the dialysis center, Brooks says. There is a lot of stuff that goes into that at the centercharting, monthly labs, weekly labs, all of the things that go on at the center that involve the physicianthat we do not see on the practice side because the chart is basically completed at the clinic.

The physicians see the patient at least once a week. Patients who come in three days a week are either on a Monday, Wednesday, Friday or a Tuesday, Thursday, Saturday schedule, and the physician sees them at least once during each cycle of visits, she explains. The physician sees the patient on the machine and right after they come off, they review the patients chart, medications, etc.

Tips for Billing for Less Than a Full Month

If the physician does not supervise the patient for the entire month, he or she must report the dialysis supervision with one of the codes for individual services per day (90922-90925).

If it is a partial month that the patient is on dialysis, you actually have to break it down by the days you provided services, Brooks explains. They cannot receive dialysis at another facility and the other facility and you both bill for the same time.

Interpreting Lab and Diagnostic Tests

Payments to the facility that provides the dialysis treatments are reimbursed by Medicare at a composite rate. Medicare policy includes many diagnostic tests used to monitor patients progress in the composite rate to the facility. Some tests are outside the composite rate, allowing separate reimbursement to the center. The physician interpretation of these tests is still included in the MCP payment to the physician, however, and should not be reported separately.

The following laboratory tests are included in the hemodialysis composite rate:

Per Treatment: All hematocrit, hemoglobin and clotting time tests furnished incident to dialysis treatments.

Weekly: Prothrombin time for patients on anti-coagulant therapy; serum creatinine

Weekly or Thirteen per Quarter: Blood urea nitrogen (BUN)

Monthly: Alkaline phosphatase, AST, CBC, LDH, serum albumin, serum bicarbonate, serum calcium, serum chloride, SGOT, serum phosphorous, serum potassium, total protein.

Only if the patient is seen in the office and the visit is not related to either the ESRD or the dialysis treatments, can the physician bill, says Brooks. If the patient comes in for a strep infection, or pneumonia or bronchitis, or something like that.

Patients with ESRD usually are very ill and have multiple health complications, usually related to their disease. If it is something truly separate, it can be reported separate from [the MCP], but you need to have plenty of documentation about that visit, she says.

Inpatient Codes

Codes 90935, 90937, 90945 and 90947 are for acute dialysis treatments in the hospital setting. If the patient is hospitalized and receives treatments there, those days must be excluded from the monthly payment and the physician should bill only for the days he provided outpatient services.

Most dialysis centers are required to have patients undergo a history and physical at least once per year. If the patient has not been hospitalized during the course of the year, the internist would need to perform an annual physical for this purpose, notes Brooks. And this would still be included in the capitated payment for dialysis.

For most of these patients, who are very sick, they will have been in the hospital at least once, she notes.

And a history and physical would be done for the admission. But if the patient has been very lucky and not had to go in, we would have to do an exam in the office.

According to Empire Medicares carrier review policy, if more than one physician provides ESRD-related services for portions of the month, each physician may bill for a portion of the MCP. But the sum of the prorated payments may not exceed the full MCP payment and the full MCP may not be billed for that month.

To receive the prorated MCP, the number of days (units) the physician provided service should be reported in Box 24G of the HCFA 1500 form (for electronic claims, in the FA0 record, field 18.0) and the payment will be prorated.

Codes for care plan oversight cannot be reported in addition to the codes for monthly ESRD-related services. No other evaluation and management services besides an initial hospital consultation, initial hospital visit or discharge day visit may be reported on the same day of a dialysis treatment.

Documentation Guidelines

Medicare policy contains documentation requirements for reporting dialysis supervision:

1. Documentation supporting the medical necessity, such as an approved ICD-9 code, must be submitted with each claim. Claims submitted without such evidence will be denied as medically unnecessary.

2. All records should document the appropriate clinical and laboratory data relevant to the patients status and the dialysis procedure performed, whether billing for the full month or any portion.

3. Records on self-dialysis patients should reflect whether the patient is trained for self-dialysis, whether training has been completed and how many sessions were involved. If additional training is necessary, the records must indicate any change in the type of dialysis, any change to a treatment machine that the patient is not trained to use, a change in dialysis setting or change in dialysis partner.

4. If the physician is billing for other than the full MCP,
he or she must have documentation indicating the reason for this billing (i.e., patient was hospitalized or received dialysis at another location).