

**REPORT FOR**  
*(Sterilized)*

PREPARED  
BY  
THE FAIRMONT GROUP, LLC



178 EARLY WYNE DRIVE  
TAYLORSVILLE, KY 40071

AUGUST 17, 2007

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## OVERVIEW OF ENGAGEMENT

Coding and compliant billing for hospital based outpatient hemodialysis centers is extremely complex. The presentation of many elements must be displayed on the UB-92 correctly in order to assure compliant and proper payment. We reviewed and analyzed data from the (*Sterilized*) Dialysis Center in regard to charge entry, billing, and reimbursement. Our primary focus was centered on identifying procedures and drugs that were included in the composite rate in addition to those that were excluded from the composite rate and separately billable. The process included:

- Validation of the Type of Bill Code located in Field Locator 4 of the UB-92.
- Validation of the Condition Code located in Field Locator 24 of the UB-92.
- Validation of the Occurrence Span Code located in Field Locator 36 of the UB-92.
- Validation of the Value Codes located in Field Locator 39-41 of the UB-92.
- Validation of the Revenue Code located in Field Locator 42 of the UB-92 for appropriateness in accordance with the updated CMS Revenue Code to Cost Center Crosswalk (Drugs, Labs and Administration Fees).
- Validation of the Healthcare Common Procedure Coding System (HCPCS) Codes and Modifiers located in Field Locator 44 of the UB-92 for appropriateness in accordance with the Updated CMS HCPCS Code Set.
- Validation of the Charge Amount for each line item reported in Field Locator 47 of the UB-92.

## TYPE OF BILL

Type of Bill (Form Locator 4) on the UB-92 claim form indicates the specific type of facility, bill classification, and frequency for services specified on the UB-92 claim form. This field, commonly known as "Bill Type," is a required field on the UB-92. This 3-digit code requires one digit each, in the following format:

- The first digit identifies the type of facility.
- The second classifies the type of care.
- The third indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code.

APPROVED OMB NO. 0938-0279										
2		3 PATIENT CONTROL NO.								4 TYPE OF BILL
5 FED. TAX NO.		8 STATEMENT COVERS PERIOD FROM		7 COV D.		8 HC D.		9 C-I D.		10 L-R D.
13 PATIENT ADDRESS										
19 TYPE		20 SRC		21 D HR		22 STAT		23 MEDICAL RECORD NO.		
24		25		26		27		28		30
35		36		37		38		39		40
41		42		43		44		45		46
47		48		49		50		51		52
53		54		55		56		57		58
59		60		61		62		63		64
65		66		67		68		69		70
71		72		73		74		75		76
77		78		79		80		81		82
83		84		85		86		87		88
89		90		91		92		93		94
95		96		97		98		99		100
a		b		c		d		e		f
g		h		i		j		k		l
m		n		o		p		q		r
s		t		u		v		w		x
y		z		aa		ab		ac		ad
ae		af		ag		ah		ai		aj
ak		al		am		an		ao		ap
aq		ar		as		at		au		av
aw		ax		ay		az		ba		bb
bc		bd		be		bf		bg		bh
bi		bj		bk		bl		bm		bn
bo		bp		bq		br		bs		bt
bu		bv		bw		bx		by		bz
ca		cb		cc		cd		ce		cf
cg		ch		ci		cj		ck		cl
cm		cn		co		cp		cq		cr
cs		ct		cu		cv		cw		cx
cy		cz		da		db		dc		dd
de		df		dg		dh		di		dj
dk		dl		dm		dn		do		dp
dq		dr		ds		dt		du		dv
dw		dx		dy		dz		ea		eb
ec		ed		ee		ef		eg		eh
ei		ej		ek		el		em		en
eo		ep		eq		er		es		et
eu		ev		ew		ex		ey		ez
fa		fb		fc		fd		fe		ff
fg		fh		fi		fj		fk		fl
fm		fn		fo		fp		fq		fr
fs		ft		fu		fv		fw		fx
fy		fz		ga		gb		gc		gd
ge		gf		gg		gh		gi		gj
gk		gl		gm		gn		go		gp
gq		gr		gs		gt		gu		gv
gw		gx		gy		gz		ha		hb
hc		hd		he		hf		hg		hh
hi		hj		hk		hl		hm		hn
ho		hp		hq		hr		hs		ht
hu		hv		hw		hx		hy		hz
ia		ib		ic		id		ie		if
ig		ih		ii		ij		ik		il
im		in		io		ip		iq		ir
is		it		iu		iv		iw		ix
iy		iz		ja		jb		jc		jd
je		jf		jg		jh		ji		jj
jk		jl		jm		jn		jo		jp
jq		jr		js		jt		ju		jv
jw		jx		jy		jz		ka		kb
kc		kd		ke		kf		kg		kh
ki		kj		kk		kl		km		kn
ko		kp		kq		kr		ks		kt
ku		kv		kw		kx		ky		kz
la		lb		lc		ld		le		lf
lh		li		lj		lk		ll		lm
ln		lo		lp		lq		lr		ls
lt		lu		lv		lw		lx		ly
lz		ma		mb		mc		md		me
mg		mh		mi		mj		mk		ml
mm		mn		mo		mp		mq		mr
ms		mt		mu		mv		mw		mx
my		mz		na		nb		nc		nd
ne		nf		ng		nh		ni		nj
nk		nl		nm		nn		no		np
nq		nr		ns		nt		nu		nv
nw		nx		ny		nz		oa		ob
oc		od		oe		of		og		oh
oi		oj		ok		ol		om		on
oo		op		oq		or		os		ot
ou		ov		ow		ox		oy		oz
pa		pb		pc		pd		pe		pf
ph		pi		pj		pk		pl		pm
pn		po		pp		pq		pr		ps
pt		pu		pv		pw		px		py
pz		qa		qb		qc		qd		qe
qh		qi		qj		qk		ql		qm
qn		qo		qp		qq		qr		qs
qt		qu		qv		qw		qx		qy
qz		ra		rb		rc		rd		re
rh		ri		rj		rk		rl		rm
rn		ro		rp		rq		rr		rs
rt		ru		rv		rw		rx		ry
rz		sa		sb		sc		sd		se
sh		si		sj		sk		sl		sm
sn		so		sp		sq		sr		ss
st		su		sv		sw		sx		sy
sz		ta		tb		tc		td		te
th		ti		tj		tk		tl		tm
tn		to		tp		tq		tr		ts
tt		tu		tv		tw		tx		ty
tz		ua		ub		uc		ud		ue
uh		ui		uj		uk		ul		um
un		uo		up		uq		ur		us
ut		uv		uw		ux		uy		uz
va		vb		vc		vd		ve		vf
vh		vi		vj		vk		vl		vm
vn		vo		vp		vq		vr		vs
vt		vu		vv		vw		vx		vy
vz		wa		wb		wc		wd		we
wh		wi		wj		wk		wl		wm
wn		wo		wp		wq		wr		ws
wt		wu		wv		ww		wx		wy
wz		xa		xb		xc		xd		xe
xh		xi		xj		xk		xl		xm
xn		xo		xp		xq		xr		xs
xt		xu		xv		xw		xx		xy
xz		ya		yb		yc		yd		ye
yh		yi		yj		yk		yl		ym
yn		yo		yp		yq		yr		ys
yt		yu		yv		yw		yx		yy
yz		za		zb		zc		zd		ze
zh		zi		zj		zk		zl		zm
zn		zo		zp		zq		zr		zs
zt		zu		zv		zw		zx		zy
zz		aa		ab		ac		ad		ae
ah		ai		aj		ak		al		am
an		ao		ap		aq		ar		as
at		au		av		aw		ax		ay
az		ba		bb		bc		bd		be
bh		bi		bj		bk		bl		bm
bn		bo		bp		bq		br		bs
bt		bu		bv		bw		bx		by
bz		ca		cb		cc		cd		ce
ch		ci		cj		ck		cl		cm
cn		co		cp		cq		cr		cs
ct		cu		cv		cw		cx		cy
cz		da		db		dc		dd		de
dh		di		dj		dk		dl		dm
dn		do		dp		dq		dr		ds
dt		du		dv		dw		dx		dy
dz		ea		eb		ec		ed		ee
eh		ei		ej		ek		el		em
en		eo		ep		eq		er		es
et		eu		ev		ew		ex		ey
ez		fa		fb		fc		fd		fe
fh		fi		fj		fk		fl		fm
fn		fo		fp		fq		fr		fs
ft		fu		fv		fw		fx		fy
fz		ga		gb		gc		gd		ge
gh		gi		gj		gk		gl		gm
gn		go		gp		gq		gr		gs
gt		gu		gv		gw		gx		gy
gz		ha		hb		hc		hd		he
hh		hi		hj		hk		hl		hm
hn		ho		hp		hq		hr		hs
ht		hu		hv		hw		hx		hy
hz		ia		ib		ic		id		ie
ih		ii		ij		ik		il		im
in		io		ip		iq		ir		is
it		iu		iv		iw		ix		iy
iz		ja		jb		jc		jd		je
jh		ji		jj		jk		jl		jm
jn		jo		jp		jq		jr		js
jt		ju		jv		jw		jx		jy
jz		ka		kb		kc		kd		ke
kh		ki		kj		kk		kl		km
kn		ko		kp		kq				

The first two digits, 72, indicate a claim for an ESRD facility. The third digit identifies the frequency of the claim being submitted. **721** is the code for “Admit Through Discharge Claim” and is used for a bill encompassing an entire course of outpatient treatment for which the provider expects payment from the payer. **721 should be utilized for (Sterilized) Regional Dialysis Center.**

## CONDITION CODE

Condition Code is reported in Field Locator 24 (FL-24). Hospital-based and independent renal facilities must complete these items. **Note that one of the codes 71-76 is applicable for every bill and must be present on all billings.**

APPROVED OMB NO. 0											
						3 PATIENT CONTROL NO.					
6 STATEMENT COVERS PERIOD FROM		THROUGH		7 COV.D.	8 N-C.D.	9 C-I.D.	10 L-R.D.	11			
PATIENT ADDRESS											
22 STAT	23 MEDICAL RECORD NO.			CONDITION CODES							31
				24	25	26	27	28	29	30	
OCCURRENCE DATE		36 CODE	OCCURRENCE SPAN FROM		THROUGH		37				
							A				
							B				
							C				
		39 CODE	VALUE CODES AMOUNT		40 CODE	VALUE CODES AMOUNT		41 CODE	VALUE CODES AMOUNT		
		a									
		b									

Code	Condition
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	Patient is HMO Enrollee - Providers enter this code to indicate the patient is a member of an HMO.
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 in Nursing Facility (NF) – Beneficiary receives home dialysis in NF including SNF. (Effective 3/3/05.)

This Condition Code should be utilized for (Sterilized)

## OCCURRENCE SPAN CODE

2										3 PATIENT CO	
5 FED. TAX NO.				6 STATEMENT COVERS PERIOD FROM THROUGH			7 COV. D.	8 N-C. D.	9 C		
13 PATIENT ADDRESS											
19 TYPE	20 SRC	21 D. HR.	22 STAT.	23 MEDICAL RECORD NO.				24	25	26	
OCCURRENCE DATE		35 CODE	OCCURRENCE DATE		36 CODE	OCCURRENCE SPAN FROM THROUGH		37 A B C			
					a	39 VALUE CODES CODE AMOUNT		40 CODE			
					b	.					
					c	.					
					d	.					
44 HCPCS / RATES				45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHARGES			

Occurrence Span Codes and Dates are required. Occurrence span codes have values from 70 through 99 and M0 through Z9. When FLs 36 A and B are fully used with occurrence span codes, FLs 34 A and B and 35 A and B may be used to contain the "From" and "Through" dates of other occurrence span codes. In this case, the code in FL 34 is the occurrence span code and the occurrence span "From" dates is in the date field. FL 35 contains the same occurrence span code as the code in FL 34, and the occurrence span "Through" date is in the date field.

Code	Title	Definition
70	Qualifying Stay Dates	(Part A claims for SNF level of care only.) The From/Through dates for a hospital stay of at least 3 days that qualifies the patient for payment of the SNF level of care services billed on this claim.
70	Nonutilization Dates (For Payer Use on Hospital Bills Only)	The From/Through dates during a PPS inlier stay for which the beneficiary has exhausted all regular days and/or coinsurance days, but which is covered on the cost report.
71	Hospital Prior Stay Dates	(Part A claims only.) The From/Through dates given by the patient of any hospital stay that ended within 60 days of this hospital or SNF admission.
72	First/Last Visit	The actual dates of the first and last visits occurring in this billing period where these dates are different from those in FL 6, Statement Covers Period.
74	Noncovered Level of Care	The From/Through dates for a period at a non-covered level of care in an otherwise covered stay, excluding any period reported with occurrence span codes 76, 77, or 79. Codes 76 and 77 apply to most non-covered care. Used for leave of absence, or for repetitive Part B services to show a period of inpatient hospital care or outpatient surgery during the billing period. Also used for HHA or hospice services billed under Part A, But not valid for HHA under PPS.

**This Occurrence Span Code should be utilized for (Sterilized)**

75	SNF Level of Care	The From/Through dates for a period of SNF level of care during an inpatient hospital stay. Since QIOs no longer routinely review inpatient hospital bills for hospitals under PPS, this code is needed only in length of stay outlier cases (code "60" in FLs 24-30). It is not applicable to swing-bed hospitals that transfer patients from the hospital to a SNF level of care.
76	Patient Liability	The From/Through dates for a period of non-covered care for which the provider is permitted to charge the beneficiary. Codes should be used only where the FI or the QIO has approved such charges in advance and the patient has been notified in writing 3 days prior to the "From" date of this period. (See occurrence codes 31 and/or 32.)
77	Provider Liability-Utilization Charged	The From/Through dates of a period of care for which the provider is liable (other than for lack of medical necessity or custodial care). The beneficiary's record is charged with Part A days, Part A or Part B deductible and Part B coinsurance. The provider may collect the Part A or Part B deductible and coinsurance from the beneficiary.
78	SNF Prior Stay Dates	(Part A claims only.) The From/Through dates given to the hospital by the patient of any SNF stay that ended within 60 days of this hospital or SNF admission. An inpatient stay in a facility or part of a facility that is certified or licensed by the State solely below a SNF level of care does not continue a spell of illness and, therefore, is not shown in FL 36. (See Chapter 1)
79	Payer Code	THIS CODE IS SET ASIDE FOR PAYER USE ONLY. PROVIDERS DO NOT REPORT THIS CODE.
M0	QIO/UR Stay Dates	If a code "C3" is in FL 24-30, the provider enters the From and Through dates of the approved billing period.
M1	Provider Liability-No Utilization	Code indicates the From/Through dates of a period of non covered care that is denied due to lack of medical necessity or as custodial care for which the provider is liable. The beneficiary is not charged with utilization. The provider may not collect Part A or Part B deductible or coinsurance from the beneficiary.
M2	Dates of Inpatient Respite Care	From/Through dates of a period of inpatient respite care for hospice patients.
M3	ICF Level of Care	The From/Through dates of a period of intermediate level of care during an inpatient hospital stay
M4	Residential Level of Care	The From/Through dates of a period of residential level of care during an inpatient stay
M5- WZ		Reserved for National Assignment
X0- ZZ		Reserved for state assignment. Discontinued, effective October 16, 2003

## VALUE CODES

APPROVED														
2						3 PATIENT CONTROL NO.								
5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM		THROUGH		7 COV. D.	8 N-C D.	9 C-I D.	10 L-R D.	11				
13 PATIENT ADDRESS														
ADMISSION 18 HR 19 TYPE 20 SRC				21 D HR	22 STAT	23 MEDICAL RECORD NO.		CONDITION CODES						
								24	25	26	27	28	29	30
34 OCCURRENCE DATE		35 OCCURRENCE DATE		36 OCCURRENCE SPAN FROM		THROUGH		37						
								A						
								B						
								C						
				39 CODE		VALUE CODES AMOUNT		40 CODE		VALUE CODES AMOUNT		41 CODE		
				a		.				.				
				b		.				.				
				c		.				.				
				d		.				.				
44 HCPCS / RATES				45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHARGES			48 NON-COVERED CHG			

Code(s) and related dollar amount(s) identify monetary data that are necessary for processing the claim. The codes are two alphanumeric digits and each value allows up to nine numeric digits (000000.00). Negative amounts are not allowed, except in FL 41. 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. There are four lines of data, line "A" through line "D." FLs 39A through 41A are used before FLs 39B through 41B (i.e., the first line is used before the second line is used and so on). Value Codes are as follows:

- 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.
- 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 hemoglobin reading taken before the last administration of Erythropoietin (EPO) during this billing cycle. This is usually reported in three positions with a decimal. Use the right of the delimiter for the third digit.

▶ **49 - Hematocrit Reading - Code indicates the hematocrit reading taken before the last administration of EPO during this billing cycle. 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.**

• 67 - Peritoneal Dialysis - The number of hours of peritoneal dialysis provided during the billing period. Count only the hours spent in the home. Exclude travel time. Report amount in whole units right-justified to the left of the dollar/cents delimiter. (Round to the nearest whole hour.)

• 68 - Erythropoietin Units - Code indicates the number of units of administered EPO relating to the billing period and reported in whole units to the left of the dollar/cents delimiter. NOTE: The total amount of EPO injected during the billing period is reported. If there were 12 doses injected, the sum of the units administered for the 12 doses is reported as the value to the left of the dollar/cents delimiter.

• 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 FI and forwarded to CWF. (See §120 for discussion of ESRD networks).

▶ **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. This height is as the patient presents.**

**Codes 49, A8 and A9 highlighted above are required and should be utilized for (Sterilized)**

## REVENUE CODES AND COMPOSITE RATE

Each line item entry must have a correct and accurate Revenue Code for that entry placed in Field Locator 42 on the UB-92 (or assigned to the field corresponding to Field Locator 42 for electronic billing).

			b
			c
			d
42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE

### Medications:

#### REVENUE CODES:

The following table demonstrates the Revenue Codes for Medications:

Revenue center ID	Revenue Code Description	Used in OPPS
0631	Drugs Require Specific ID: Single source drug	Y
0632	Drugs Require Specific ID: Multiple source drug	Y
0633	Drugs Require Specific ID: Restrictive prescription	Y
0634	Drugs Require Specific ID: EPO under 10,000 units	Y
0635	Drugs Require Specific ID: EPO over 10,000 units	Y
0636	Drugs Require Specific ID: Drugs requiring detail coding	Y
0637	Drugs Require Specific ID: Self admin drugs (insulin admin in emergency-diabetes coma)	Y

Revenue Center Code 0636 should be utilized for *(Sterilized) Drugs*

#### COMPOSITE RATE:

In accordance with the Medicare Benefit Policy Manual, Chapter 11, §§30.4.1 (Rev. 1, 10-01-03)-Drugs Covered Under the Composite Rate, certain drugs used in the dialysis procedure are covered under the facility's composite rate and may not be billed separately. Drugs that are used as a substitute for any of these items, or are used to accomplish the same effect, are also covered under the composite rate. The administration of these items (both the staff time and the supplies) is covered under the composite rate and may not be billed separately.

The following table is a listing of those drugs included in the composite rate calculations.

#### Dialysis Composite Medications

Heparin	Insulin	Solu-cortef	Verapamil
Antiarrhythmics	Lidocaine	Glucose	Antihistamines
Protamine	Mannitol	Antihypertensives	Dextrose
Local Anesthetics	Saline	Heparin antidotes	Inderal
Apresoline (hydralazine)	Pressor drugs	Benadryl	Antibiotics *
Dopamine	Lanoxin	Levophed	

\* Antibiotics (when used at home by a patient to treat an infection of the catheter site or peritonitis associated with peritoneal dialysis)

**MEDICATIONS NOT INCLUDED IN COMPOSITE RATE:**

Based on facility treatment trends and analysis, the following medications can be billed separately and are not included in the composite rate:

**Medications that can be billed separately:**

- J7192 Factor VIII (anti-hemophilic factor, recombinant), per IU  
Genarc, Helixate FS, Refacto, Recombinate, Kogenate, Advate, Kogenate FS Bio-set
- J1756 Injection, iron sucrose, 1 mg  
Venofer
- J0882 Injection, darbepoetin alfa, 1 microgram (for ESRD on dialysis)  
Aranesp

**Laboratory Procedures:**

**REVENUE CODES:**

The following table demonstrates the Revenue Codes for Laboratory Procedures:

Revenue center ID	Revenue Code Description	Used in OPSS
0300	Laboratory - Clinical Diagnostic	Y
0301	Laboratory - Clinical Diagnostic: Chemistry	Y
0302	Laboratory - Clinical Diagnostic: Immunology	Y
0303	Laboratory - Clinical Diagnostic: Renal patient (home)	Y
<b>0304</b>	<b>Laboratory - Clinical Diagnostic: Nonroutine dialysis</b>	<b>Y</b>
0305	Laboratory - Clinical Diagnostic: Hematology	Y
0306	Laboratory - Clinical Diagnostic: Bacteriology/microbiology	Y
0307	Laboratory - Clinical Diagnostic: Urology	Y
0309	Laboratory - Clinical Diagnostic: Other laboratory	Y

Revenue Center Code 0304 should be utilized for (*Sterilized*) Laboratory Tests

**COMPOSITE RATE:**

An appropriate valid HCPCS Code and Modifier for the item billed must be placed in Field Locator 44 of the UB-92. In accordance with the Medicare Benefit Policy Manual, Chapter 11, §§30.2.xx (Rev. 67, 03-09-07), the costs of certain ESRD laboratory services performed by either the facility’s staff, or an independent laboratory, are included in the composite rate calculations and may not be billed separately. Below you will find a list of these tests that are taken from §§30.2.1 and 70.2.A. (See §§50.1, 60.1, and 80 of the Medicare Claims Processing Manual, Chapter 8, “Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims,” for payment instructions.) The tests highlighted are those that CAN be billed separately. Those tests that are not highlighted are included in the composite rate calculations. Those tests that are not highlighted and have an “X” in the adjacent columns are those tests that are included in the composite rate calculation except when done more often than once (when medically necessary) in the indicated time frame.

**Dialysis Composite Lab Tests**

Chemistry	CPT Code	Monthly	Weekly	13 x Quarter
Albumin	82040	X		
Alkaline Phosphatase	84075	X		
<b>ALT (SGPT)</b>	<b>84460</b>			
AST (SGOT)	84450	X		

**Dialysis Composite Lab Tests (cont.)**

Chemistry	CPT Code	Monthly	Weekly	13 x Quarter
<b>Bilirubin, total</b>	<b>82247</b>			
<b>Bilirubin, direct</b>	<b>82248</b>			
Calcium	82310	X		
Chloride	82435	X		
<b>Cholesterol</b>	<b>82465</b>			
<b>CK, CPK</b>	<b>82550</b>			
CO2 (bicarbonate)	82374	X		
Creatinine	82565		X	
<b>GGT</b>	<b>82977</b>			
<b>Glucose</b>	<b>82947</b>			
LDH	83615	X		
Phosphorus	84100	X		
Potassium	84132	X		
Protein, total	84155	X		
<b>Sodium</b>	<b>84295</b>			
<b>Triglycerides</b>	<b>84478</b>			
Urea nitrogen (BUN)	84520			X
<b>Uric Acid</b>	<b>84550</b>			

**\*\* The highlighted labs noted in the above chart are labs that are most commonly performed at (Sterilized)**

**LABS NOT INCLUDED IN COMPOSITE RATE:**

Based on facility treatment trends and analysis, the following laboratory tests can be billed separately and are not included in the composite rate:

**Labs that can be billed separately:**

- 86803 Hepatitis C antibody
- 86706 Hepatitis B surface antibody (HBsAB)
- 86703 Antibody; HIV-1 and HIV-2, single assay
- 85045 Blood count; reticulocyte, automated
- 84478 CF Triglycerides
- 84443 Thyroid stimulating hormone (TSH)
- 84437 Thyroxine; requiring elution (eg, neonatal)
- 83718 Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)
- 83550 Iron binding capacity
- 83540 Iron
- 82947 CF Glucose; quantitative, blood (except reagent strip)
- 82728 Ferritin
- 82607 Cyanocobalamin (Vitamin B-12)
- 82465 CF Cholesterol, serum or whole blood, total

\* CF Modifier: AMCC test has been ordered by an ESRD facility or MCP physician that is not part of the composite rate and is separately billable

**SUPPLIES NOT INCLUDED IN COMPOSITE RATE:**

REVENUE CODE for supplies: The **Revenue Center Code 0270** should be utilized when billing **A4657 (Syringes)** for (Sterilized)

Based on (Sterilized) trends and analysis, the following supplies can be billed separately and are not included in the composite rate:

**Supplies that can be billed separately:**

- A4657 Syringe, with or without needle, each

In accordance with Medlearn Matters #SE0527 - Providers cannot bill HCPCS code A4657 for ESRD patients when billing for a pre-filled syringe used in the administration of the drug contained in the syringe and no other syringe is used. Only when a new syringe is used in the administration of the drug should HCPCS A4657 be used.

**Administration:**

**REVENUE CENTER CODES:**

The following table demonstrates the Revenue Codes for Hemodialysis:

Revenue center ID	Revenue Code Description	Used in OPPS
0820	Hemo OPD/Home	Y
0821	Hemo OPD/Home: Hemodialysis comp or other rate	Y
0822	Hemo OPD/Home supplies	Y
0823	Hemo OPD/home equipment	Y
0824	Hemo OPD/Home Maintenance 100%	Y
0825	Hemo OPD/Home Support Services	Y
0829	Hemo OPD/Home: Other HEMO outpatient	Y
0830	Peritoneal OPD/Home	Y
0831	Peritoneal OPD/Home: Peritoneal comp or other rate	Y

Revenue Center Code 0821 should be utilized for (Sterilized)

**HCPCS CODES:**

HCPCS Code **90999** - Unlisted dialysis procedure, in-patient, or outpatient

**Modifiers that may be appropriate for use with 90999**

AQ	Physician providing a service in an unlisted health professional shortage area (HPSA)
AR	Physician provider services in a physician scarcity area
G1	Most recent Urea Reduction Ratio (URR) reading of less than 60
G2	Most recent Urea Reduction Ratio (URR) reading of 60 to 64.9
G3	Most recent Urea Reduction Ratio (URR) reading of 65 to 69.9
G4	Most recent Urea Reduction Ratio (URR) reading of 70 to 74.9
G5	Most recent Urea Reduction Ratio (URR) reading of 75 or greater
G6	ERSD patient for whom less than six dialysis sessions have been provided in a month.
GA	Waiver of liability statement on file
GZ	Item or service expected to be denied as not reasonable and necessary

\* **Urea Reduction Rate (URR)** is the measurement of the fractional urea clearance during a single dialysis treatment. This ratio is expressed as a percentage and is calculated as:

$$[(\text{predialysis BUN} - \text{postdialysis BUN}) / \text{predialysis BUN}] * 100$$

The HCPCS Code 90999 carries an Out-patient Prospective System (OPPS) or Ambulator Patient Classification (APC) Status Indicator (SI) of "B". The following describes the "B" SI:

Indicator	Item/Code/Service	OPPS Payment Status
B	Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x, and 13x)	Not paid under OPPS <ul style="list-style-type: none"> <li>• May be paid by intermediaries when submitted on a different bill type, for example, 75X (CORF), but not paid under OPPS.</li> <li>• An alternate code that is recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x, and 13x) may be available.</li> </ul>

Therefore, the HCPCS Code 90999 is paid on a "Cost Basis" method. In order to determine an appropriate charge for this procedure, we referred to the HCPCS Code 90945, which is described as "Dialysis, one evaluation." According to "CMS1506FC Addendum B" this code carries a "Payment Rate" of \$406.24 and a "Minimum Unadjusted Copayment" of \$81.25. Combining the

two rates will obtain a **suggested Fee Schedule Rate for 90999 of \$487.49 or \$485.00 when rounded.**

**SERVICE UNITS:**

	b	.	.	.	.
	c	.	.	.	.
	d	.	.	.	.
	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-C
				.	.
				.	.
				.	.
				.	.
				.	.
				.	.
				.	.

Enter the number of units rendered for each service in Field Locator 46. Units can be hours, days/sessions, tests/services or items. Incorrect reporting of service units will result in a compliance issue.

**TOTAL CHARGES:**

	b	.	.	.	.
	c	.	.	.	.
	d	.	.	.	.
HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
			.	.	.
			.	.	.
			.	.	.
			.	.	.
			.	.	.
			.	.	.
			.	.	.

Enter total charges pertaining to the related revenue code for the current billing period in Field Locator 47. Zeros are valid. An entry is required for each revenue code entered.

**CHARGE VALIDATION FOR MEDICATION:**

The current charges for Medications frequently used by *(Sterilized)* that are exempt from the composite rate were reviewed for appropriateness. The method used to calculate the noted Suggested Charge was 400% above the Average Wholesale Price (AWP) respectively for each medication as listed in the current Blue Book. Also, the Payment Limit listed was based on the values noted in the CMS July 07 ASP by HCPCS updated 06/26/07.

Medications	AWP	Payment Limit	Current Charges	Suggested Charge
J7192 - Factor VIII (anti-hemophilic factor, recombinant), per IU Genarc, Helixate FS, Refacto, Recombinate, Kogenate, Advate, Kogenate FS Bio-set	\$1.99	\$1.08	\$45.65	\$7.96
J1756 - Injection, iron sucrose, 1 mg Venofer	\$0.69	\$0.38	\$15.00	\$2.75
J0882 - Injection, darbepoetin alfa, 1 microgram (for ESRD on dialysis) Aranesp	\$5.78	\$3.05	\$59.40	\$23.12

**CHARGE VALIDATION FOR LABORATORY PROCEDURES:**

The current charges for Laboratory Procedures frequently used by *(Sterilized)* that are exempt from the composite rate were reviewed for appropriateness. The method used to calculate the noted Suggested Charge was 400% above the Medicare Allowable as noted for Tennessee as reported in the CMS 2007 Clinical Diagnostic Laboratory Fee Schedule.

Laboratory Procedures (w/Modifiers)		MCR fee	Current Charges	Suggest Charge
86803	Hepatitis C antibody	\$ 19.94	\$ 99.93	\$ 79.76
86706	Hepatitis B surface antibody (HBsAB)	\$ 15.01	\$ 99.93	\$ 60.04
86703	Antibody; HIV-1 and HIV-2, single assay	\$ 19.17	\$ 105.00	\$ 76.68
85045	Blood count; reticulocyte, automated	\$ 5.59	\$ 44.00	\$ 22.36
84478	CF Triglycerides	\$ 8.04	\$ 121.44	\$ 32.16
84443	Thyroid stimulating hormone (TSH)	\$ 23.47	\$ 47.30	\$ 93.88
84437	Thyroxine; requiring elution (eg, neonatal)	\$ 9.04	\$ 75.08	\$ 36.16
83718	Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)	\$ 11.44	\$ 79.70	\$ 45.76
83550	Iron binding capacity	\$ 12.21	\$ 83.49	\$ 48.84
83540	Iron	\$ 9.05	\$ 61.99	\$ 36.20
82947	CF Glucose; quantitative, blood (except reagent strip)	\$ 5.48	\$ 37.40	\$ 21.92
82728	Ferritin	\$ 19.03	\$ 127.77	\$ 76.12
82607	Cyanocobalamin (Vitamin B-12)	\$ 21.06	\$ 138.16	\$ 84.24
82465	CF Cholesterol, serum or whole blood, total	\$ 6.08	\$ 41.75	\$ 24.32

**CHARGE VALIDATION FOR SUPPLIES:**

The current charge for A4657 (Syringe with or without needle) is \$30.25. We suggest no change in this current charge.

**MEDICAL RECORDS REVIEW**

According to Medicare Rules and Regulations, we reviewed the following 18 Medical Records for evidence of a valid physician's order for treatment or procedures. All contained a valid physician's order. A copy of that order is maintained in the Department.

**Medical Charts Reviewed**

List Contains PHI  
*(Sterilized)*

## RECOMMENDATIONS

1. Due to the complex nature of billing for dialysis services, we would recommend monthly random sampled audits of all the areas outlined in this report.
2. Decrease hemodialyses treatment charge reported under revenue code 821 to \$485.00.
3. Decrease Medication charges as identified in this report.
4. Decrease Laboratory Procedure charges as identified in this report.
5. Establish a Intake Coordinator that would facilitate eligibility and insure payment arrangements for patients receiving services from *(Sterilized)*.
6. Yearly review of CPT and Modifiers used in billing for *(Sterilized)*.

We would recommend reviewing 12 months of *(Sterilized)* denials and performing a root cause analysis to determine why the claims were denied and make changes to system to minimize denials in the future based on those findings.