**Definitions**

**ESRD** – End Stage Renal Disease

**Monthly Capitation Payment Method** (“MCP”) – A comprehensive monthly payment that covers all physician's services associated with the continuing medical management of a maintenance dialysis patient.

**NPPs** – Non-Physician Practitioners such as Physician Assistants or Advanced Registered Nurse Practitioners who are enrolled in the Medicare program.

**MCP Physician** – Physician under whose provider number the charge for the monthly capitation payment is submitted.

**Non-MCP Physician** – A Physician who may provide one or more of the face-to-face visits with the patient during the month but who does not perform the complete assessment, does not establish the patient's plan of care, and does not provide the ongoing management of the patient.

**Resident/Fellow** - An individual who participates in an approved GME program, including programs in osteopathy, dentistry, and podiatry. For the purpose of federal rules includes interns and fellows, as well as residents.

“Resident” also includes a physician who is not in an approved GME program, but who is authorized to practice only in a hospital setting, i.e., physicians with temporary or restricted licenses or unlicensed graduates of foreign medical schools.
Teaching Physician - A physician (other than another resident or fellow) who involves residents in the care of his or her patients.

**Background**

Effective 1/1/04, CPT-4 procedure codes 90918-90921 for ESRD related services reimbursed by Medicare under the MCP method hold a Medicare Payment Policy Indicator of “I” in the Code Status category. This means these codes are no longer valid for Medicare billing purposes. Medicare has created new HCPCs Level II codes to replace the CPT-4 codes.

The new HCPCs Level II codes (“G codes”) are still distinguished by the age of the patient. However, the change made reflects varying payments based on the number of face-to-face patient visits provided within each month to an ESRD patient.

There are separate codes for use when the physician provides 1 visit per month, 2-3 visits per month, and 4 or more visits per month based on the patient’s age. The code for 1 visit per month would be paid less than the code for 2-3 visits and the highest payment would be received for 4 or more visits per month. These codes would be reported once per month for services performed in an outpatient setting that are related to the patient’s ESRD.

The new code range to be used for ESRD patients (other than home dialysis) is:

G0308 through G0319

*A complete list of the new codes and their descriptions can be found in the 2004 version of HCPCs Level II.*

**Role of NPPs**

NPPs may be used to deliver some of the visits during the month if they are enrolled in the Medicare program and are able to submit charges to Medicare under their individual provider number.

The rules for these NPPs would be consistent with the rules for split/shared evaluation and management visits as long as the MCP Physician and the NPP are in the same group practice. The MCP Physician must perform some portion of the service in a face-to-face encounter, in this case one or more visits during the month with the patient.

In this situation, however, to bill the service under the MCP physician’s provider number, the MCP Physician and not the NPP should be the one to perform the visit with the complete assessment of the patient and to establish the patient’s plan of care.
If the NPP is the provider who performs the complete assessment and establishes the plan of care, the charge should be billed under the NPPs provider number and not the MCP Physician’s provider number.

**Use of Another Physician to Provide Some of the Visits During the Month**

Another physician who has a relationship with the MCP Physician (such as partner or employees of the same group practice) may be used to provide some of the visits during the month. This provider would be considered the Non-MCP physician.

However, the physician who provides the complete assessment, establishes the patient’s plan of care and provides the ongoing management should be the physician who submits the bill for the monthly service.

**Residents/Fellows Providing Some of the Visits During the Month**

A resident or fellow who has a relationship with the MCP Physician (such as Teaching Physician and Resident/Fellow) may be used to provide some of the visits during the month.

However, the physician who provides the complete assessment, establishes the patient’s plan of care and provides the ongoing management would be the physician who submits the bill for the monthly service.

Since Medicare Part B does not reimburse for the services of Residents or Fellows (who are not practicing in a valid moonlighting capacity), the Teaching Physician would need to provide the complete assessment, establish the patient’s plan of care and provide the ongoing management. The Teaching Physician would then meet the criteria for MCP Physician and the bill for the monthly service would be submitted under the provider number of the MCP Physician.

**Documentation**

Each practitioner must document in a shared medical record services he/she personally performed. Only one practitioner can bill for the management of the ESRD patient in any month.

When an NPP or a “rounding physician” sees a dialysis patient for management of ESRD, they cannot bill an Evaluation and Management service for the same patient unless there is a separate, substantial and documented service evaluating the patient for care unrelated to the patient’s dialysis.
Documentation should include information that is clinically relevant, including but not limited to the following:

- the patient’s current status and complaints;
- a clinically appropriate physical examination;
- assessment of the patient’s treatment for ESRD;
- assessment of the adequacy of the dialysis treatment;
- the status of the patient’s vascular access;
- assessment and treatment of any other conditions associated with the ESRD, such as anemia, electrolyte management, and bone density; and
- changes to the patient’s management

**What is Included in the New Codes**

These services continue to include the establishment of a dialyzing cycle, outpatient evaluation and management of the dialysis visits, telephone calls, and patient management provided during a full month.

**Valid Locations of Service**

Visits for the management of ESRD patients may occur in the physician’s office, in an outpatient hospital or other outpatient setting or even in the patient’s home as well as in the dialysis facility.

**Hospitalization During the Month**

These codes would not be used if the patient were hospitalized during the entire month.

For ESRD patients (other than home dialysis patients) who are hospitalized during part of the month, the MCP physician may bill the code that reflects the number of face-to-face visits during the month on days when the patient was not in the hospital (either admitted as an inpatient or in observation status).