

**CAUTION: Read the [ICD-9 Policy Holding Library](#) page about policy in this document.**

dial ex cms

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## Dialysis Example: CMS-1500

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The example in this section is to assist providers in billing for dialysis on the *CMS-1500* claim. Refer to the *Dialysis: End Stage Renal Disease Services* section of this manual for detailed policy information. Refer to the *CMS-1500 Completion* section of this manual for instructions to complete claim fields not explained in the following examples. For additional claim preparation information, refer to the *Forms: Legibility and Completion Standards* section of this manual.

**Billing Tips:** When completing claims, do not enter the decimal points in ICD-9-CM codes or dollar amounts. If requested information does not fit neatly in the *Reserved for Local Use* field (Box 19) of the claim, type it on an 8½ x 11-inch sheet of paper and attach it to the claim.

**Hemodialysis***Figure 1. Hemodialysis.*

*This is a sample only. Please adapt to your billing situation.*

CPT-4 code 90989 (dialysis training, patient, including helper where applicable, any mode, completed course) is entered in the *Procedures, Services or Supplies* field (Box 24D).

The dialysis training service is being billed in the “from-through” format in the *Date(s) of Service* field (Box 24A). The “from” date of service for code 90989 is the first date the recipient was seen for the training. In this case, June 1, 2007 is entered as 060107 on claim line 1 as the “from” date. The “through” or “to” date of service (June 30, 2007), which is the end date of the training, is entered in the “through” column as 063007.

As a requirement for “from-through” billing, each date of service must be listed in the *Reserved for Local Use* field (Box 19). Also entered in this field is the condition (renal failure) that results in the patient’s need for hemodialysis. This information is optional but facilitates claim processing.

In this example, ICD-9-CM code 584 (acute renal failure) is entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21).

Enter the usual and customary charges in the *Charges* field (Box 24F). Enter a 1 in the *Days or Units* field (Box 24G) for CPT-4 code 90989 to indicate that one month of service is being billed.

<p><b>1500</b></p> <p><b>HEALTH INSURANCE CLAIM FORM</b></p> <p>APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05</p>																																																																																									
<p>PICA <input type="checkbox"/> PICA <input type="checkbox"/></p>																																																																																									
<p>1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/></p> <p>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</p>						<p>1a. INSURED'S I.D. NUMBER (For Program in Item 1)</p> <p><b>9000000A95001</b></p>																																																																																			
<p>2. PATIENT'S NAME (Last Name, First Name, Middle Initial)</p> <p><b>DOE JOHN</b></p>						<p>3. PATIENT'S BIRTH DATE SEX</p> <p><b>06 21 62</b> M <input checked="" type="checkbox"/> F <input type="checkbox"/></p>			<p>4. INSURED'S NAME (Last Name, First Name, Middle Initial)</p>																																																																																
<p>5. PATIENT'S ADDRESS (No., Street)</p> <p><b>1234 MAIN STREET</b></p>						<p>6. PATIENT RELATIONSHIP TO INSURED</p> <p>Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/></p>			<p>7. INSURED'S ADDRESS (No., Street)</p>																																																																																
<p>CITY</p> <p><b>ANYTOWN</b></p>				<p>STATE</p> <p><b>CA</b></p>		<p>8. PATIENT STATUS</p> <p>Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/></p>			<p>CITY</p>			<p>STATE</p>																																																																													
<p>ZIP CODE</p> <p><b>95823</b></p>				<p>TELEPHONE (Include Area Code)</p> <p><b>(916) 555-5555</b></p>		<p>Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/></p>			<p>ZIP CODE</p>			<p>TELEPHONE (Include Area Code)</p> <p>( )</p>																																																																													
<p>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</p>						<p>10. IS PATIENT'S CONDITION RELATED TO:</p>			<p>11. INSURED'S POLICY GROUP OR FECA NUMBER</p>																																																																																
<p>a. OTHER INSURED'S POLICY OR GROUP NUMBER</p>						<p>a. EMPLOYMENT? (Current or Previous)</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p>			<p>a. INSURED'S DATE OF BIRTH SEX</p> <p>MM DD YY M <input type="checkbox"/> F <input type="checkbox"/></p>			<p>b. EMPLOYER'S NAME OR SCHOOL NAME</p>																																																																													
<p>b. OTHER INSURED'S DATE OF BIRTH SEX</p> <p>MM DD YY M <input type="checkbox"/> F <input type="checkbox"/></p>						<p>b. AUTO ACCIDENT? PLACE (State)</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>			<p>c. INSURANCE PLAN NAME OR PROGRAM NAME</p>			<p>d. IS THERE ANOTHER HEALTH BENEFIT PLAN?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i></p>																																																																													
<p>c. EMPLOYER'S NAME OR SCHOOL NAME</p>						<p>c. OTHER ACCIDENT?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>			<p>10d. RESERVED FOR LOCAL USE</p>			<p>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</p>																																																																													
<p>d. INSURANCE PLAN NAME OR PROGRAM NAME</p>						<p>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.</p>			<p>SIGNED</p>			<p>SIGNED</p>																																																																													
<p><b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b></p>																																																																																									
<p>14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)</p> <p>MM DD YY</p>						<p>15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE</p> <p>MM DD YY</p>			<p>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</p> <p>FROM MM DD YY TO MM DD YY</p>																																																																																
<p>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE</p>						<p>17a. NPI</p>			<p>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</p> <p>FROM MM DD YY TO MM DD YY</p>																																																																																
<p>19. RESERVED FOR LOCAL USE</p>																																																																																									
<p><b>RENAL FAILURE. HEMODIALYSIS TREATMENTS: 6/01, 6/04, 6/08, 6/12, 6/16, 6/20, 6/24, 6/28</b></p>																																																																																									
<p>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)</p> <p>1. <b>584</b></p>																																																																																									
<p>24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSTD Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #</p>																																																																																									
<table border="1"> <tr> <td>1</td> <td>06</td> <td>01</td> <td>07</td> <td>06</td> <td>30</td> <td>07</td> <td>22</td> <td>90989</td> <td></td> <td>65000</td> <td>1</td> <td>NPI</td> </tr> <tr> <td>2</td> <td></td> <td>NPI</td> </tr> <tr> <td>3</td> <td></td> <td>NPI</td> </tr> <tr> <td>4</td> <td></td> <td>NPI</td> </tr> <tr> <td>5</td> <td></td> <td>NPI</td> </tr> <tr> <td>6</td> <td></td> <td>NPI</td> </tr> </table>												1	06	01	07	06	30	07	22	90989		65000	1	NPI	2												NPI	3												NPI	4												NPI	5												NPI	6												NPI
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<p>25. FEDERAL TAX I.D. NUMBER SSN EIN</p>				<p>26. PATIENT'S ACCOUNT NO.</p>				<p>27. ACCEPT ASSIGNMENT? (If gov. claims, see b330)</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>		<p>28. TOTAL CHARGE</p> <p>\$ <b>65000</b></p>		<p>29. AMOUNT PAID</p> <p>\$</p>		<p>30. BALANCE DUE</p> <p>\$ <b>65000</b></p>																																																																											
<p>31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)</p> <p><i>Jane Doe</i></p> <p>SIGNED DATE <b>06/30/07</b></p>						<p>32. SERVICE FACILITY LOCATION INFORMATION</p> <p>a. NPI b.</p>						<p>33. BILLING PROVIDER INFO &amp; PH # <b>(916) 555-5555</b></p> <p><b>JANE SMITH</b> <b>1027 MAIN STREET</b> <b>ANYTOWN CA 958235555</b></p> <p>a. <b>0123456789</b> b.</p>																																																																													
<p>NUCC Instruction Manual available at: <a href="http://www.nucc.org">www.nucc.org</a></p>																																																																																									
<p>APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)</p>																																																																																									

Figure 1. Hemodialysis.