Dialysis Adequacy, Infection, and Vascular Access Reporting – JA6782

Note: This Job Aid was revised to add a note on page 3, regarding the use of Healthcare Common Procedure Coding Systems (HCPCS) 90999 in dialysis revenue code lines in order to report the required infection modifiers.

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Date Job Aid Revised: June 2, 2010

Effective Date: July 1, 2010

Implementation Date: July 6, 2010

Key Words	MM6782, CR6782, R1932CP, Dialysis, Adequacy, Infection, Vascular
Contractors Affected	• Part A/B Medicare Administrative Contractors (A/B MACs) • Fiscal Intermediaries (FIs)
Provider Types Affected	Renal Dialysis Facilities submitting claims to FIs and A/B MACs for services to Medicare beneficiaries

- CR6782 requires new quality data reporting for dialysis adequacy, infection, and vascular access on all End Stage Renal Disease (ESRD) claims and all ESRD Hemodialysis claims with dates of service on or after July 1, 2010.
- The new data reporting will allow the Centers for Medicare & Medicaid Services (CMS) to implement an accurate quality incentive payment for dialysis providers by January 1, 2012, as required by Section 153c of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).

Provider Needs to Know…

New Quality Data Required on all ESRD Claims

- New quality data is required on all ESRD claims with dates of service on or after July 1, 2010.

Claim Level Codes

- Value code D5: Result of last Kt/V (K-dialyzer clearance of urea; t-dialysis time; V-patient's total body water) reading
  - For in-center hemodialysis patients, this is the last reading taken during the billing

period.

  - For peritoneal dialysis patients (and home hemodialysis patients), this may be before the current billing period but should be within 4 months of the claim date of service.
- Occurrence code 51: Date of last Kt/V reading
  - For in-center hemodialysis patients, this is the date of the last reading taken during the billing period.
  - For peritoneal dialysis patients (and home hemodialysis patients), this date may be before the current billing period but should be within 4 months of the claim date of service.

Kt/V Test Not Performed

- In the event that the provider has not performed the Kt/V test for the patient, the provider must attest that no test was performed by reporting the value code D5 with a 9.99 value.
- The occurrence code date should not be reported on the claim in the case of no Kt/V reading being reported.

Failure to Report D5 Value

- For dates of service on or after July 1, 2010, failure to report the D5 value code on the 72x bill type will result in the claim being returned to the provider.
- In addition, Medicare will return 72x bill types with dates of service on or after July 1, 2010, to the provider if the claim does not contain occurrence code 51, except where there is a D5 value code with 9.99.

Line Level Codes

- The following line level codes are to be reported on dialysis revenue code lines:

  Modifier V8
  - Dialysis access-related infection is present (documented and treated) during the billing month.
  - Reportable dialysis access-related infection is limited to peritonitis for peritoneal dialysis patients or bacteremia for hemodialysis patients.
  - Facilities must report any peritonitis related to a peritoneal dialysis catheter and any bacteremia related to hemodialysis access (including arteriovenous fistula, arteriovenous graft, or vascular catheter) if identified during the billing month.
  - For individuals that receive different modalities of dialysis during the billing month and an infection is identified, the V8 code should only be indicated on the claim for the patient's primary dialysis modality at the time the infection was first suspected.
  - Non-access related infections should not be coded as V8.
  - If no dialysis-access related infection is present by this definition, providers should instead report modifier V9.

Modifier V9

- No dialysis-access related infection, as defined for modifier V8, is present during the billing month.
- Dialysis access-related infection, defined as peritonitis for peritoneal dialysis patients or bacteremia for hemodialysis patients, must be reported using modifier V8.
- Providers must report any peritonitis related to a peritoneal dialysis catheter and any bacteremia related to hemodialysis access (including arteriovenous fistula, arteriovenous graft, or vascular catheter) using modifier V8.

Note: Medicare systems will return to the provider 72x bill types with dates of service on or after July 1, 2010, when the modifier V8 or V9 is not present on each dialysis revenue code line (0821, 0831, 0841, or 0851). Providers may report HCPCS 90999 in all dialysis revenue code lines in order to report the required infection modifiers.

New Quality Data on all ESRD Hemodialysis Claims

- New quality data is required on All ESRD Hemodialysis claims with dates of service on or after July 1, 2010.

Line Level Codes to be Reported on Hemodialysis Revenue Code Lines

- Vascular Access for ESRD Hemodialysis Patients - An indicator of the type of vascular access used for the delivery of hemodialysis at the last hemodialysis session of the month. The code is required to be reported on the latest line item date of service billing for hemodialysis revenue code 0821. It may be reported on all revenue code 0821 lines at the discretion of the provider as follows:
  - Modifier V5: Any Vascular Catheter (alone or with any other vascular access)
  - Modifier V6: Arteriovenous Graft (or other vascular access not including a vascular catheter)
  - Modifier V7: Arteriovenous Fistula Only (in use with two needles).

Note: Medicare systems will return to the provider 72x bill types with dates of service on or after July 1, 2010, billing for hemodialysis when the latest line item date of service billing for revenue code 0821 does not contain one of the following modifiers: V5, V6, or V7.

Medicare Integrated Code Editor

- The modifiers V5-V9 are effective January 1, 2010.
- The Medicare Integrated Code Editor has been updated to allow the reporting of these codes for claims with dates of service on or after January 1, 2010.
- Therefore, providers may voluntarily report these modifiers for claims with dates of service January 1, 2010, through July 1, 2010.

- Section 153c of MIPPA requires CMS to implement a quality based payment program for dialysis services effective January 1, 2012.
- CMS currently collects two monthly measurements of quality of care via the ESRD claims submitted by dialysis providers: hemoglobin or hematocrit as a measure of anemia management and urea reduction ratio (URR) as a measure of hemodialysis adequacy.
- The source data for the two current quality measures are collected on dialysis provider claims. The anemia management quality measure uses the most recent hemoglobin or hematocrit lab value that was collected using value codes 48 or 49 on bill type 72x.
- The hemodialysis adequacy measure uses the current month's URR lab value collected, using HCPCS modifiers G1 through G6 on hemodialysis line items (revenue center 082x and HCPCS 90999).
- These two quality measures meet the minimum requirements as mandated in Section 153c of MIPPA.
- However, the URR measure of dialysis adequacy does not provide data for the entire ESRD dialysis population. Not having dialysis adequacy data for a segment of the dialysis population (peritoneal dialysis patients) is problematic in the development of a quality-based payment program that will decrease provider payment by up to 2 percent based on quality outcome data. This missing data does not enable CMS to assess all ESRD dialysis providers based on the same criteria.

Background

- Section 153c also requires the use of quality measures endorsed by a consensus organization.
- CMS recently reexamined and received National Quality Forum (NQF) endorsement for the ESRD quality measures.
- Both CMS and NQF found that dialysis adequacy is best measured by Kt/V for both hemodialysis and peritoneal dialysis patients.
- The NQF granted time-limited endorsement of URR for hemodialysis patients and recommended that CMS drop it in favor of Kt/V as soon as possible.
- While dialysis adequacy is measured monthly for in-center hemodialysis patients, dialysis adequacy is measured less frequently for peritoneal dialysis patients (at least every four months). Therefore, it is necessary to track both the date of the most recent measurement and the result of the most recent measurement.
- Finally, Section 153c of MIPPA provides for the use of additional quality measures for the quality based payment program as determined by the Secretary of Health and Human Services.
- Two additional quality measures could easily be collected, using HCPCS modifiers for hemodialysis patients to record vascular access.
- The first measure is use of an arteriovenous fistula with two needles, which is recognized as the best vascular access because it is associated with the least infections.

- The second measure is the use of any vascular catheter, which is recognized as the worst vascular access because it is associated with the most infections. Collecting vascular access data will allow CMS to develop a more robust quality based payment program in order to implement national policy without additional data collection burden on dialysis providers, who are already required to collect these data under the Fistula First Initiative.
- Consequently, CMS will require the reporting of the Kt/V reading and date of the reading, vascular access, and infection data on ESRD claims with dates of service on or after July 1, 2010.
- This new data reporting requirement will allow CMS to implement an accurate quality incentive payment for dialysis providers by January 1, 2012, as required by Section 153c of MIPPA.
- The July 2010 implementation date is needed because the quality incentive payment must be in part based on provider improvement over time. Therefore, CMS requires an accurate measurement of baseline provider performance. CMS will require that providers continue to report the existing G1 through G6 modifiers for URR at this time.

Operational Impact	N/A
Reference Materials	The related MLN Matters® article can be found at *http://www.cms.gov/MLNMattersArticles/downloads/MM6782.pdf* on the CMS website. The official instruction (CR6782) regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R1932CP.pdf* on the CMS website.