Medicare Learning Network
MLN Matters®
CMS
Information for Medicare Fee-For-Service Health Care Professionals

MLN Matters Number: MM3554 Revised
Related CR Release Date: November 19, 2004
Related CR Transmittal #: 27 and 373
Related Change Request (CR) #: 3554
Effective Date: January 1, 2005
Implementation Date: January 1, 2005

New ESRD Composite Payment Rates Effective January 1, 2005

Note: Note: This article was updated on May 12, 2013, to reflect current Web addresses. This article was preiously revised to make reference to MLN Matters®, MM7064, at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM7064.pdf regarding where to get information on the new ESRD PPS and consolidated billing for limited Part B services. All other information remains unchanged.

Provider Types Affected

Renal Dialysis Facilities (RDFs)

Provider Action Needed

STOP – Impact to You

Section 623 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) mandates that the current ESRD composite payment rates be increased by 1.6 percent for dialysis treatments furnished on or after January 1, 2005. The statute further mandates that the composite payment rates must also include a drug add-on adjustment of 8.7 percent for the difference between the payment amounts for separately billable drugs and biologicals and their acquisition costs, as determined by Inspector General (IG) reports.

CAUTION – What You Need to Know

Section 623(d) of the MMA requires a basic case-mix adjusted composite rate for ESRD facility services and also requires a budget neutrality adjustment. (See MLN

Matters article MM3572 for details on the case-mix and prospective payment rates.)

GO – What You Need to Do

To ensure accurate claims processing, please review the information included here and stay current with updated instructions for ESRD Composite Payment Rates.

Background

Section 623 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA), includes major provisions which affect the development of revised End Stage Renal Disease (ESRD) composite payment rates effective for services furnished on or after January 1, 2005.

The statute mandates that the current composite payment rates be increased by 1.6 percent for dialysis treatments furnished on or after January 1, 2005. The statute further mandates that the composite payment rates must also include a drug add-on adjustment for the difference between the payment amounts for separately billable drugs and biologicals and their acquisition costs, as determined by Inspector General (IG) reports.

The fiscal intermediaries will utilize the rates in Tables 1 and 2 in the Attachments to CR3554 to determine the new composite payment rates for each renal facility located in an urban or rural area. Table 1 lists the new composite rates for each renal facility located in an urban area. Table 2 lists the new composite rates for renal facilities in rural areas.

(To view CR3554 and these tables, go to http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R373CP.pdf.)

In accordance with the appropriate provisions of §623 of the MMA, the rates in the Attachments were calculated as follows:

- The wage-adjusted composite payment rates in effect on December 31, 2004 were increased by 1.6 percent as required by §623(a)(3);
- These new rates were further increased by a drug add-on adjustment (or multiplier) in the amount of 8.7 percent. (This drug add-on adjustment represents the difference between the current payment of 95% of AWP for separately billed drugs and biologicals, and $10.00 per 1,000 units for EPO, and the acquisition costs of such drugs and biologicals, as determined by

Inspector General reports to the Secretary as required by §623(c) and §623(d)(1)(B) of the MMA.)

Note that, effective January 1, 2005, the cost for supplies to administer EPO/Aranesp may also be billed to your fiscal intermediary. Previously, Medicare made no additional payment for such supplies.

In accordance with additional requirements in CR3554, renal facilities should:

- Use Condition Code 59 when ESRD beneficiaries receive dialysis services at a facility that is not the beneficiary's home facility (the non-home facility providing dialysis services will utilize CC 59 on the TOB 72X);
- Populate Value Code (VC) A8 with the patient's weight (from the last dialysis session of the month) in kilograms up to two decimal places on all ESRD claims;
- Populate VC A9 with the height (from the last dialysis session of the month) in centimeters on Type of Bill (TOB) 72X; and
- Use HCPCS code A4657 with Revenue Code 270 for injection supplies used in the administration of EPO/Aranesp in all RDFs.

Additional Information

To view the official instructions issued to your fiscal intermediary regarding this change, go to http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R27BP.pdf and http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R373CP.pdf on the CMS website.

If you have questions regarding this issue, you may also contact your fiscal intermediary at their toll free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.