



News Flash – The Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) encourage public comment on two regulations issued on 12/30/2009 that lay a foundation for improving quality, efficiency and safety through meaningful use of certified electronic health record (EHR) technology. CMS and ONC worked closely to develop the two rules and received input from hundreds of technical subject matters experts, health care providers, and other key stakeholders. The CMS proposed rule and related fact sheets may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Legislation/Recovery/index.html> on the CMS website. The ONC's interim final rule may be viewed at <http://healthit.hhs.gov/standardsandcertification> on the Internet.

MLN Matters® Number: MM6782 **Revised**

Related Change Request (CR) #: 6782

Related CR Release Date: March 17, 2010

Effective Date: July 1, 2010

Related CR Transmittal #: R1932CP

Implementation Date: July 6, 2010

Dialysis Adequacy, Infection and Vascular Access Reporting

Note: This article was updated on December 11, 2012, to reflect current Web addresses. This article was previously revised on May 27, 2010, to add a note at the bottom of page 4 regarding the use of HCPCS 90999 in dialysis revenue code lines in order to report the required infection modifiers. All other information remains the same.

Provider Types Affected

Renal Dialysis Facilities (RDFs) submitting claims to Fiscal Intermediaries (FIs) and A/B Medicare Administrative Contractors (A/B MACs) for services to Medicare beneficiaries are impacted by this issue.

Provider Action Needed



STOP – Impact to You

Renal Dialysis Facilities (RDFs) need to know that CR 6782 requires new quality data reporting for dialysis adequacy, infection and vascular access on **all End**

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Stage Renal Disease (ESRD) claims and all ESRD Hemodialysis claims with dates of service on or after July 1, 2010.



CAUTION – What You Need to Know

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 the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) section 153c.



GO – What You Need to Do

Make sure that your billing staffs are aware of these new reporting and claim requirements described below.

Background

This article is based on CR 6782, which explains that section 153c of the 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, collected using value codes 48 or 49 on bill type 72x. The hemodialysis adequacy measure uses the current month's urea reduction ratio (URR) lab value, collected using Healthcare Common Procedure Coding Systems (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 MIPPA section 153c. 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% based on quality outcome data because, with the missing data, CMS will not be able to assess all ESRD dialysis providers based on the same criteria.

MIPPA section 153c also requires the use of quality measures endorsed by a consensus organization. CMS recently reexamined and received National Quality

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Forum (NOF) endorsement for the ESRD quality measures. Both CMS and NOF found that dialysis adequacy is best measured by Kt/V (K-dialyzer clearance of urea; t-dialysis time; V-patient's total body water) for both hemodialysis and peritoneal dialysis patients. The NOF 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, MIPPA section 153c 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 MIPPA, section 153c. The July 2010 implementation date is needed because the quality incentive payment must be in part based on provider improvement over time; thus, CMS requires an accurate measurement of baseline provider performance. The CMS will require that providers continue to report the existing G1 through G6 modifiers for URR at this time.

New quality data 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 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.

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- **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.

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. 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. Also, 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 to be reported on dialysis revenue code lines:

- **Modifier V8:** Dialysis access-related infection 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, 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 either the modifier V8 or V9 is not present on each dialysis revenue code line (0821, 0831, 0841, or 0851). Providers may

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report HCPCS 90999 in all dialysis revenue code lines in order to report the required infection modifiers.

New quality data 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.

- **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.

The modifiers V5-V9 are effective January 1, 2010, and 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.

Additional Information

For complete details regarding this CR, please see the official instruction issued to your Medicare FI or A/B MAC, which is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1932CP.pdf> on the CMS website.

If you have questions, please contact your Medicare FI or A/B MAC 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.

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