

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



All providers and suppliers who enrolled in the Medicare program prior to March 25, 2011, will have their enrollment revalidated under new risk screening criteria required by the Affordable Care Act (section 6401a). Do NOT send in revalidated enrollment forms until you are notified to do so by your Medicare Administrative Contractor. You will receive a notice to revalidate between now and March 2013. For more information about provider revalidation, review MLN Matters® Special Edition Article SE1126, which is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1126.pdf> on the Centers for Medicare & Medicaid Services website.

MLN Matters® Number: MM7471

Related Change Request (CR) #: CR 7471

Related CR Release Date: August 19, 2011

Effective Date: January 1, 2012

Related CR Transmittal #: R2281CP

Implementation Date: January 3, 2012

Implementation of Changes to the End Stage Renal Disease (ESRD) Prospective Payment System (PPS) Outlier Payment Policy and Changes to the ESRD PPS Consolidated Billing (CB) Requirements for Laboratory Services Furnished in a Hospital Emergency Room or Department

Note: This article was revised on January 4, 2014, to add a reference to MLN Matters® article MM7617 (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7617.pdf>) for more updated information regarding the changes implemented in CR7471. All other information remains the same.

Provider Types Affected

Providers and suppliers submitting claims to Medicare contractors ((Fiscal Intermediaries (FIs) and/or A/B Medicare Administrative Contractors (A/B MACs)) for laboratory services provided to Medicare ESRD beneficiaries in a hospital Emergency Room or department.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2010 American Medical Association.

Provider Action Needed



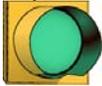
STOP – Impact to You

This article is based on Change Request (CR) 7471 which provides revisions to the End Stage Renal Disease (ESRD) Prospective Payment System (PPS) outlier services and a Consolidated Billing (CB) bypass for laboratory services billed with an emergency room service.



CAUTION – What You Need to Know

For Calendar Year (CY) 2012, the Centers for Medicare & Medicaid Services (CMS) is making the following policy changes to the ESRD PPS outlier policy. CMS is 1) eliminating the Part B drug-specific list to allow all non-composite rate ESRD-related drugs with a HCPCS and an ASP rate to be eligible for the outlier payment; and 2) eliminating, as of January 1, 2012, the requirement that hospitals append an AY modifier to laboratory tests that are billed as part of an emergency room or department visit.



GO – What You Need to Do

See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

The Medicare Improvements for Patients and Providers Act (MIPPA; Section 153(b)) required the implementation of an End Stage Renal Disease (ESRD) bundled Prospective Payment System (PPS) effective January 1, 2011. Change Request (CR) 7064 (Transmittal R2134CP dated January 14, 2011,) implemented the bundled PPS effective January 1, 2011. Medicare regulations (42 CFR 413.237(a)(1)) provides that ESRD outlier services are those ESRD-related services that 1) were or would have been considered separately billable under Medicare Part B, or 2) would have been separately payable drugs under Medicare Part D (excluding ESRD-related oral-only drugs), for renal dialysis services furnished prior to January 1, 2011.

You can find

- MIPPA, Section 153(b), at <http://www.govtrack.us/congress/billtext.xpd?bill=h110-6331> on the Internet,
- The MLN Matters® article corresponding to CR7064 (Transmittal R2134CP dated January 14, 2011,) at <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM7064.pdf> on the Centers for Medicare & Medicaid Services (CMS) website, and
- 42 CFR 413.237(a)(1) at <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr;sid=772c4252601164de94c95be51f45cc43;rgn=div2;view=text;node=20100812%3A1.30;idno=42;cc=ecfr;start=1;size=25> on the Internet.

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Subsequent to the publication of the ESRD PPS final rule, CMS concluded that any CMS prepared lists of drugs and biologicals recognized as outlier services may be difficult to keep up-to-date. Because of the large number of Part B drugs and biologicals that may be considered ESRD-related eligible outlier service drugs, effective January 1, 2012, CMS is eliminating the issuance of a list of former Part B drugs and biologicals that would be eligible for outlier payments. As a result, all ESRD-related Part B drugs and biologicals reported with a Healthcare Common Procedure Coding System (HCPCS) code that is on the Average Sales Price (ASP) List will be included for outlier payments (with the exception of composite rate drugs).

In an emergency room or emergency department, diagnostic laboratory testing is ordered according to the illness the patient is presenting, and it may not be feasible for the ordering physician to know at the time the laboratory test is being ordered if it is being ordered for reasons of treating the patient's ESRD. Emergency rooms or emergency departments will not be required to append an AY modifier to these laboratory tests when submitting claims with dates of service on or after January 1, 2012.

Note: Allowing laboratory testing to bypass CB edits in the emergency room or department does not mean that ESRD facilities should send patients to the emergency room or department for routine laboratory testing or for the provision of renal dialysis services that should be provided by ESRD facilities.

Additional Information

The official instruction, CR7471, issued to your FI or A/B MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2281CP.pdf> on the CMS website.

If you have any questions, please contact your 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.

News Flash - Protect Your Patients. Protect Your Family. Protect Yourself. Flu seasons are unpredictable and can be severe. Each year, approximately 90 percent of seasonal flu-related deaths and more than 60 percent of seasonal flu-related hospitalizations occur in people 65 years and older. Please encourage your Medicare patients to get an annual flu shot. A flu shot is important for healthcare workers too, who may spread the flu to high risk patients. The flu vaccine plus its administration are covered Part B benefits. The flu vaccine is NOT a Part D-covered drug. For more information on coverage and billing of the flu vaccine and its administration, and related educational provider resources, visit the following CMS webpages: [Medicare Learning Network® Preventive Services](#) and [Immunizations](#). **Get the Flu Vaccine -- Not the Flu.**

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