

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



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MLN Matters® Number: MM7593 **Revised**

Related Change Request (CR) #: CR 7593

Related CR Release Date: November 25, 2011

Effective Date: Effective January 1, 2012 and April 1, 2012 as indicated in the Background Section below.

Related CR Transmittal #: R2361CP

Implementation Date: April 2, 2012

Clarification and Revisions for Claims Submitted for End Stage Renal Disease (ESRD) Patients

Note: This article was revised on November 28, 2011, to reflect changes made to CR7593 on November 25, 2011. In the article, the CR release date, transmittal number, and the Web address for accessing CR7593 were revised. All other information remains the same.

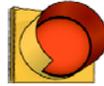
Provider Types Affected

Providers and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare ESRD beneficiaries.

Provider Action Needed

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**STOP – Impact to You**

This article is based on Change Request (CR) 7593 which includes several revisions and clarifications regarding instructions published for the ESRD, Prospective Payment System (ESRD PPS) and the ESRD Quality Incentive Program (ESRD QIP).

**CAUTION – What You Need to Know**

These clarifications and revisions include 1) A clarification on the onset of dialysis adjustment for ESRD Claims, 2) A revision to ESRD claims reporting the drug Vancomycin, 3) A revision to hospitals reporting emergency related laboratory services, 4) A clarification of ESRD claims reporting the Kt/V value, and 5) A revision to ESRD claim requirements for reporting hematocrit and hemoglobin readings for all ESRD patients.

**GO – What You Need to Do**

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

Background

CR7593 includes several revisions and clarifications regarding the instructions published for the ESRD PPS and the ESRD QIP as follows:

1. Clarification of the Onset of Dialysis Adjustment for ESRD Claims

The 2011 final rule for the ESRD PPS, published on August 12, 2010, implemented a case-mix adjusted bundled PPS, effective January 1, 2011. In this rule, the Centers for Medicare & Medicaid Services (CMS) finalized a payment adjustment for dialysis treatments furnished to adults for onset of dialysis. This adjustment is applied to each dialysis treatment that is furnished to adult patients who are eligible to receive Medicare coverage during their first 120 calendar days of dialysis. This adjustment is determined by the dialysis start date in the Common Working File as provided on the CMS Form 2728 (ESRD medical evidence report medicare entitlement and/or patient registration form) completed by the provider and certified by the practitioner.

Subsequent to the publication of the ESRD PPS final rule, there has been confusion as to how often the onset of dialysis adjustment can apply. The onset of dialysis is a one-time adjustment. That is, payment for the onset of dialysis is only provided during the initial 120 calendar days from when an ESRD beneficiary began their maintenance dialysis. The

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onset of dialysis adjustment does not restart and apply when a patient receives dialysis at a different facility or when dialysis resumes after a failed kidney transplant.

Effective April 1, 2012, Medicare system changes will be implemented to support the existing policy.

2. Revision to ESRD Claims Reporting Vancomycin

CR7064 (Transmittal 2134; End Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Consolidated Billing for Limited Part B Services) implemented the ESRD PPS.

CR7064 provided ESRD consolidated billing requirements for certain Part B services included in the ESRD facility bundled payment. See the MLN article corresponding to CR7046 at <https://www.cms.gov/MLN MattersArticles/downloads/MM7064.pdf> on the CMS website. All drugs reported on the ESRD facility claim that do not have an 'AY' (Item or service furnished to an ESRD patient that is not for the treatment of ESRD) modifier are considered included in the ESRD PPS. The list of drugs and biologicals for consolidated billing are designated as always ESRD-related and, therefore, separate payment is not made to ESRD facilities. However, subsequent to the publication of the Calendar Year (CY) 2011 ESRD PPS final rule and CR7064, CMS received numerous comments indicating that Vancomycin is indicated for both ESRD and non-ESRD conditions. After consultation with CMS Medical Advisors, CMS concurs with this assessment.

Effective January 1, 2012, ESRD facilities have the ability to receive separate payment for Vancomycin furnished on or after January 1, 2012, by placing the 'AY' modifier on the claim when Vancomycin is furnished to treat non-ESRD related conditions. The ESRD facility is required to indicate (in accordance with International Classifications of Diseases, Ninth Revision (ICD-9) guidelines) the diagnosis code for which the Vancomycin is indicated. CMS contractors are advised to reprocess ESRD claims with dates of service from January 1, 2012, through March 31, 2012, containing Vancomycin with the 'AY' modifier.

3. Revision to Hospitals Reporting Emergency Related Laboratory Services

CR7471 (Transmittal 2266; 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 Requirements for Laboratory Services Furnished in a Hospital Emergency Room or Department) implemented a bypass of the ESRD PPS consolidated billing requirements for ESRD-related laboratory services furnished to ESRD patients in an emergency room or emergency department on the same date of service as the emergency visit.

Subsequent to the issuance of CR7471, CMS found that there are situations where an ESRD-related laboratory service may be furnished to an ESRD patient in an emergency

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room or emergency department on a different date of service. For example, the patient may have gone to the emergency room at 10:30pm one evening but did not receive laboratory testing until 1:00am the next day. This instruction will allow for identifying and reporting of emergency related laboratory services not performed on the same date of service as the emergency visit.

Effective April 1, 2012, CMS is requiring that hospitals append an 'ET' (Emergency services) modifier to ESRD-related laboratory tests furnished to ESRD patients on a day other than the date of the emergency room or emergency department visit to indicate that the laboratory test was furnished in conjunction with the emergency visit. Appending the 'ET' modifier indicates that the laboratory service being furnished on a day other than the emergency visit is related to the emergency visit. Therefore, at the time the laboratory test was ordered, the ordering physician was unable to determine if it is being ordered for reasons of treating the patient's ESRD.

4. Clarification of ESRD Claims Reporting the Kt/V Value

CR7460 (Transmittal 2262; Implementation of the MIPPA 153c End Stage Renal Disease (ESRD) Quality Incentive Program (QIP) and Other Requirements for ESRD Claims) provided instructions for calculating the Kt/V value for reporting on the claim. See the MLN Matters article corresponding to CR7460 at

<https://www.cms.gov/MLN MattersArticles/downloads/MM7460.pdf> on the CMS website.

When reporting a value of 8.88 the date of a Kt/V reading is not required. However the standard system will require a date until April 1, 2012. Facilities that do not have a date to report may use any date within the billing period until April when the date will no longer be required.

Effective January 1, 2012, when reporting a value of 8.88 the date of a Kt/V reading is not required. **However, the standard system will require a date until April 1, 2012.** System changes will be implemented to no longer require a date be reported when the value being reported is 8.88.

5. Revision to ESRD Claim Requirements for Reporting a Hematocrit or Hemoglobin

CR7460 (Transmittal 2262; Implementation of the MIPPA 153c End Stage Renal Disease (ESRD) Quality Incentive Program (QIP) and Other Requirements for ESRD Claims) provided requirements for ESRD facilities to report a hematocrit or hemoglobin reading all ESRD claims. See the MLN Matters article corresponding to CR7460 at

<https://www.cms.gov/MLN MattersArticles/downloads/MM7460.pdf> on the CMS website.

However, CR 7460 did not provide instructions in the event a facility does not have a hematocrit or hemoglobin reading to report. As a result, this instruction will require that a facility that does not have a hematocrit or hemoglobin to report must submit a default value of 99.99 to indicate no reading was available. In compliance with the CMS long-standing policy that requires that a hematocrit or hemoglobin be reported when an Erythropoiesis Stimulating Agent (ESA) is administered, the value 99.99 may not be used.

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Effective April 1, 2012, when a facility does not have a hematocrit or hemoglobin to report, the facility shall report a value of 99.99 with either the value code 48 (Hemoglobin reading) or value code 49 (Hematocrit reading). Failure to report either a hematocrit or hemoglobin reading on an ESRD claim will result in the claim being returned to the provider. When billing for an ESA the value 99.99 will not be acceptable.

Additional Information

The official instruction, CR7593, issued to your FIs and A/B MACs regarding this change may be viewed at

<http://www.cms.gov/Transmittals/downloads/R2361CP.pdf> on the CMS website.

If you have any questions, please contact your FIs or A/B MACs at their toll-free number, which may be found at

<http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

News Flash –Vaccinate Early to Protect Against the Flu /2011-2012 Influenza Vaccine Prices Are Now Available

CDC recommends a yearly flu vaccination as the most important step in protecting against flu viruses. Remind your patients that annual vaccination is recommended for optimal protection. Under Medicare Part B, Medicare pays for the flu vaccine and its administration for seniors and other Medicare beneficiaries with no co-pay or deductible. Take advantage of each office visit and start protecting your patients as soon as your 2011-2012 seasonal flu vaccine arrives. And don't forget to immunize yourself and your staff. Get the Flu Vaccination – Not the Flu.

CMS has posted the 2011-2012 seasonal influenza vaccine payment limits at:

http://www.CMS.gov/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp on the CMS website.

Influenza vaccine is NOT a Part D-covered drug. For information about Medicare's coverage of the influenza vaccine, its administration, and educational resources for healthcare professionals and their staff, visit http://www.CMS.gov/MLNProducts/35_PreventiveServices.asp on the CMS website

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