DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

News Flash – The "Rehabilitation Therapy Information Resource for Medicare" fact sheet has been revised and is now available in downloadable format from the Medicare Learning Network® at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Rehab_Therapy_Fact_Sheet.pdf on the Centers for Medicare & Medicaid Services (CMS) website. This fact sheet is designed to provide education on rehabilitation therapy services and includes information on coverage requirements, billing and payment information, and a list of contacts and resources.

MLN Matters® Number: MM7460 Revised

Related Change Request (CR) #: CR 7460

Related CR Release Date: September 23, 2011

Effective Date: January 1, 2012

Related CR Transmittal #: R2311CP

Implementation Date: January 3, 2012

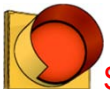
Implementation of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) 153c End Stage Renal Disease (ESRD) Quality Incentive Program (QIP) and Other Requirements for ESRD Claims

Note: This article was updated on September 4, 2012, to reflect current Web addresses. It was previously revised on December 7, 2011, 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 a full summary of ESRD PPS payment policy for CY2012. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

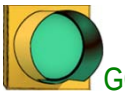


STOP – Impact to You

This article is based on Change Request (CR) 7460 which announces the implementation of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA; Section 153c) End Stage Renal Disease (ESRD) Quality Incentive Program (QIP) and other requirements for ESRD claims.

CAUTION – What You Need to Know

MIPPA (Section 153c) requires the Centers for Medicare & Medicaid Services (CMS) to implement an ESRD Quality Incentive Program (QIP) effective January 1, 2012, that will result in payment reductions to providers of services and dialysis facilities that do not meet or exceed a total performance score with respect to performance standards established for certain specified measures.



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 of 2008 (MIPPA; Section153c) requires the Centers for Medicare & Medicaid Services (CMS) to implement a quality based payment program for dialysis services with payment consequences effective January 1, 2012. This QIP will result in payment reductions to providers of ESRD services and dialysis facilities that do not meet or exceed a total performance score with respect to performance standards established for certain specified measures. The ESRD QIP is the first Medicare program which will link payments to performance based on outcomes as assessed through specific quality measures.

These measures are defined in the annual Dialysis Facility Report (DFR) that each provider receives in addition to the final rule. The payment reductions will:

- Apply to payment for renal dialysis services furnished on or after January 1, 2012;
- Be up to 2.0 percent of payments otherwise made to ESRD facilities;
- Apply only to the year involved for an ESRD facility; and
- Not be taken into account when computing future payment rates for the impacted facility.

In addition to implementing the QIP, CMS will require ESRD facilities to provide the following on ALL ESRD claims with dates of service on or after January 1, 2012:

- The hemoglobin and/or hematocrit value(s);
- The route of administration of Erythropoiesis Stimulating Agents (ESAs) using the JA or JB modifier code for any claim indicating the administration of ESAs;
- The Kt/V (calculated using a specified formula) indicating the measurement of dialysis adequacy.

Note: Failure to include the JA or JB modifier for ESA route of administration when reporting Q4081 or J0882 on a 72X type of bill will result in that bill being returned to the provider.

CMS is making these changes to assess:

- The management of anemia for ESRD patients;
- The safety of the administration of ESAs; and
- The adequacy of the dialysis provided to ESRD patients using a standardized methodology for the calculation of Kt/V.

These changes will enable CMS to meet the intent of the MIPPA (Section 153c) legislation to monitor safety and outcomes delivered by ESRD providers for the entire ESRD population as part of the QIP. QIP reductions, where appropriate, will be applied to ESRD PPS payments (and composite rate portion of the payment for transitioning providers). In addition, any QIP reduction will also apply to ESRD related separately billable services for ESRD facilities under the ESRD PPS transitional payment through December 31, 2013.

Reporting Hemoglobin and/or Hematocrit:

CMS will require the submission of the most recent hemoglobin or hematocrit lab value taken prior to the start of the billing period on all ESRD claims irrespective of ESA administration. Failure to submit a hemoglobin and/or hematocrit value on all ESRD claims will adversely impact a facility's QIP score and public reporting on Dialysis Facility Compare (DFC). Note: *The blood sample for the hemoglobin reading must be obtained before the dialysis treatment. If a hemoglobin value is not available the value 99.99 shall be entered.*

Required Reporting for ESA Route of Administration:

When reporting the administration of ESAs, CMS will require the reporting of modifiers JA (intravenous administration) or JB (subcutaneous administration) indicating the route of administration on all ESRD claims with dates of service on or after January 1, 2012.

ESRD claims that do not contain modifier JA or JB (when ESA administration is indicated) will be returned to the provider for correction. Patients with ESRD receiving administrations of ESAs (such as epoetin alfa (EPO) and Darbepoetin alfa (Aranesp)) for the treatment of anemia may receive intravenous administration or subcutaneous administrations of the ESA. Existing instructions require that ESRD facilities submit each administration on a separate line item. Renal dialysis facility claims including administrations of the ESAs by both methods must report the appropriate route of administration for each line item.

Calculation of the Kt/V Value:

CMS will require the use of the following Kt/V calculations based on the dialytic modality when entering Value Code D5 on ESRD claims.

- **Hemodialysis**: For in-center and home-hemodialysis patients prescribed for three or fewer treatments per week, the last Kt/V obtained during the month must be reported. Facilities must report single pool Kt/V using the preferred National Quality Forum (NQF) endorsed methods for deriving the single pool Kt/V value:
  - Daugirdas II or
  - Urea Kinetic Modeling (UKM).

  Note: The reported Kt/V should not include residual renal function.

  A value of 8.88 should be entered on the claim, for patients routinely prescribed and receiving four or more hemodialysis treatments per week for a medically justified and documented clinical need. The 8.88 value is not to be used for patients who are receiving "extra" treatments for temporary clinical need (e.g., fluid overload). A medical justification must be submitted for patients receiving greater than 13 treatments per month

  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. Providers 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.

- **Peritoneal Dialysis**: When measured, the delivered weekly total Kt/V (dialytic and residual) should be reported.

Coding for Vascular Access on Hemodialysis Claims:

Modifier V5 must be entered if a vascular catheter is present even if it is not being used for the delivery of the hemodialysis. In this instance 2 modifiers should be entered, V5 (Any Vascular Catheter (alone or with any other vascular access)) for the vascular catheter and either V6 (Arteriovenous Graft (or other Vascular Access not including a vascular catheter in use with two needles)) or V7 (Arteriovenous Fistula Only (in use with two needles)) for the access that is being used for the delivery of hemodialysis.

Note: All other requirements associated with ESRD claims will remain unchanged.

Additional Information

The official instruction, CR7460, issued to your FI or A/B MACs regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2311CP.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.

Note: This article was revised on September 26, 2011, to reflect a new CR 7460, which corrected the definition of the hemodialysis Kt/V that is used in the calculation of the Kt/V value. The article was previously changed to include a statement on page 3 to assist providers with coding Hemoglobin or Hematocrit with 99.99 when a value is not available for a patient, a statement on page 4 to assist providers in coding a date for a Kt/V reading when submitting a value of 8.88 prior to April 1, 2012, and a statement on page 4 to assist providers with the coding of Vascular Access type modifiers on hemodialysis claims.

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/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html 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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html on the CMS website