

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



**MLN Matters® Articles Index:** Have you ever tried to search MLN Matters® articles for information regarding a certain issue, but you did not know what year it was published? To assist you next time in your search, try the CMS article indexes that are published at <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/MLNMattersArticles/> on the CMS website. These indexes resemble the index in the back of a book and contain keywords found in the articles, including HCPCS codes and modifiers. These are published every month. Just search for a keyword(s) and you will find articles that contain those word(s). Then just click on one of the related article numbers and it will open that document. Give it a try.

**MLN Matters® Number:** MM8898

**Related Change Request (CR) #:** CR 8898

**Related CR Release Date:** October 24, 2014

**Effective Date:** January 1, 2011

**Related CR Transmittal #:** R197BP

**Implementation Date:** January 5, 2015

### **Clarification of the End Stage Renal Disease (ESRD) Prospective Payment System (PPS) Low Volume Adjustment**

**Note:** This article was revised on March 2, 2016, to add a reference to MLN Matters® article [MM9478](#) which, effective January 1, 2016, removed the grandfathering of ESRD facilities that were Medicare certified prior to January 1, 2011, and changed the geographic proximity criteria for the LVPA. All other information remains the same.

#### **Provider Types Affected**

This MLN Matters® Article is intended for End Stage Renal Disease (ESRD) facilities that submit claims to Medicare Administrative Contractors (MACs) for renal dialysis services provided to Medicare beneficiaries.

#### **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 2013 American Medical Association.

## What You Need to Know

---

Change Request (CR) 8898 provides clarification for two criteria required for the validation of the ESRD PPS low volume payment adjustment (LVPA).

Specifically, CR 8898 clarifies the criteria required for the validation of the ESRD PPS LVPA related to:

1. The treatment count requirements for hospital-based ESRD facilities using cost report data and other supporting documents, and
2. When a change of ownership for any ESRD facility does not result in a new provider transaction access number (PTAN) but does result in a new cost reporting period.

CR 8898 also revises the "Medicare Benefit Policy Manual," Chapter 11 (End Stage Renal Disease (ESRD), Section 60 (ESRD PPS Case-Mix Adjustments)) to reflect these clarifications. Make sure that your billing staff are aware of the clarifications and revisions.

## Background

---

For an ESRD facility to qualify for the LVPA, certain criteria must be attested to by the ESRD facility and validated by its MAC. The qualifying criteria include:

- Furnishing less than 4,000 dialysis treatments in each of the 3 cost reporting years preceding its payment year;
- The facility must not have opened, closed, or received a new provider number due to change in ownership in the 3 years preceding the payment year; and
- The facility must not be located within 25 road miles of another ESRD facility under common ownership.

The geographic proximity criterion is only applicable to ESRD facilities that are Medicare certified on or after January 1, 2011, to furnish outpatient maintenance dialysis treatments.

CR 8898 clarifies two criteria required for the validation of the LVPA. The two criteria needing clarification are:

1. The treatment count requirements for hospital-based ESRD facilities using cost report data and other supporting documents, and
2. When a change of ownership for any ESRD facility does not result in a new PTAN but does result in a new cost reporting period.

The first criteria needing clarification relates to hospital-based ESRD facilities meeting the requirement of furnishing less than 4,000 dialysis treatments in each of the 3 cost reporting years preceding the payment year. In the situation where a hospital has multiple locations of a hospital-based ESRD facility under its governing body, the aggregate cost and treatment data of all of the locations (not just the treatment count of one of the sub-units or satellite entities) are reported on the hospital's cost report. In the case where a hospital has multiple locations reported on its cost report, the MAC may consider other supporting data in addition to the total treatments reported in each of the 12-consecutive month cost reports,

### 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 2013 American Medical Association.

including other supporting documentation which may include individual facility treatment counts, rather than the hospital's cost report alone. The hospital must provide the documentation to support the total treatment count for all the facilities that make up the total treatment count on the cost report for the MAC to review, even if not all the facilities are applying for the low volume adjustment.

The second criteria needing clarification is related to any ESRD facility that has a change of ownership (CHOW), but does not obtain a new provider transaction access number (PTAN). If there is a change in ownership that does not result in a change in provider number but does cause a change in the original fiscal year to that of the new provider, resulting in two non-standard cost reporting periods, then the MAC should either:

- Combine the two non-standard cost reports that equals 12 consecutive months, or
- Where the two non-standard cost reporting periods in combination exceed 12 consecutive months, prorate the data to equal a full 12 consecutive month period.

For example, prior to a CHOW, Facility A had a cost reporting period that spanned January 1 through December 31. Facility A had a CHOW mid-year that did not result in a new PTAN but caused a break in the cost reporting period. The MAC would add Facility A's cost report that spanned January 1 through May 31 to its cost report that spanned June 1 through December 31 to verify the total treatment count. The other situation that could occur is when a CHOW results in a change of the original fiscal period. For example, prior to a CHOW, Facility B had a cost reporting period that spanned January 1 through December 31 and, based on its cost reports for 2012 and 2013, it met the LVPA eligibility criteria. Then, Facility B had a CHOW in the beginning of 2014 that did not result in a new PTAN, but changed its cost reporting period to that of its new owner, October 1, 2014, through September 30, 2015. This scenario would create a short and a long cost report that would not total 12 months that the MAC would need to review for verification. That is, Facility B would have a cost report that spanned January 1, 2014, through July 31, 2014 (7 months) and a cost report that spanned August 1, 2014, through September 30, 2015 (14 months). In this situation, the MAC should combine the two non-standard cost reporting periods that in combination may exceed 12-consecutive months and prorate the data to equal a full 12-consecutive month period.

CMS realizes that these two clarifications may change the outcome for some ESRD facilities requesting the LVPA. As a result, ESRD facilities that wish to attest for the LVPA may submit attestations for each year applicable between 2011 and 2015. The timeframe for submission of these attestations will be extended until December 31, 2014. MACs will review the attestations and determine applicability for each previous year submitted by the facility. If the MAC validation results in applying the LVPA to a facility (facilities) that has (have) had claims paid without the adjustment, the MAC will adjust all claims during the applicable payment year(s) within 6 months of approving the attestation. CMS believes these clarifications will impact less than 1 percent of ESRD facilities that have less than 4000 treatments in any given year.

In addition, CMS reiterates the long-standing policy that allows for a maximum of 13 treatment payments per 30-day month, 14 treatment payments per 31 day month for all

#### 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 2013 American Medical Association.

ESRD claims. MACs may consider additional documentation to support the medical justification for payment of additional treatments.

## Additional Information

---

The official instruction, CR 8898, issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R197BP.pdf> on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Net/work-MLN/MLNMattersArticles/index.html> under - How Does It Work.

## Document History

---

Date of Change	Description
February 25, 2016	The article was revised to add a reference to MLN Matters® article <a href="#">MM9478</a> which, effective January 1, 2016, removed the grandfathering of ESRD facilities that were Medicare certified prior to January 1, 2011, and changed the geographic proximity criteria for the LVPA.

### 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 2013 American Medical Association.