CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2347	**Date: November 18, 2011**
	Change Request 7626

SUBJECT: Recoupment of Incorrect Payments Made Under the End Stage Renal Disease (ESRD) Prospective Payment System (PPS) for the Low-Volume Payment Adjustment

I. SUMMARY OF CHANGES: The purpose of this transmittal is to notify Fiscal Intermediaries or Part A or Part B Medicare Administrative Contractors that they are to perform the necessary claim adjustments to rescind the low volume adjustment for ESRD facilities not meeting the eligibility criteria.

EFFECTIVE DATE: January 1, 2012
IMPLEMENTATION DATE: January 3, 2012

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	8/20.1/Calculation of the Basic Case-Mix Adjusted Composite Rate and the ESRD Prospective Payment System Rate

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2347	Date: November 18, 2011	Change Request: 7626

SUBJECT: Recoupment of Incorrect Payments Made Under the End Stage Renal Disease (ESRD) Prospective Payment System (PPS) for the Low-Volume Payment Adjustment

Effective Date: January 1, 2012

Implementation Date: January 3, 2012

I. GENERAL INFORMATION

A. Background: Section 153(b) of the Medicare Improvements for Patients and Providers Act (MIPPA), Pub. L. 110-275 amended section 1881(b)(12) of the Act by requiring the implementation of an ESRD PPS effective January 1, 2011. Section 1881(b)(14)(D)(iii) of the Act requires that the ESRD PPS establish a low-volume payment adjustment. On August 12, 2010, we published in the Federal Register, the final rule implementing the ESRD PPS (75 FR 49030). In the ESRD PPS final rule for CY 2011 (75 FR 49200), we finalized 42 CFR §413.232 which specifies the eligibility criteria for an ESRD facility to qualify for the low-volume payment adjustment.

B. Policy: An ESRD facility is eligible for the low-volume payment adjustment only when it has met the criteria defined in 42 CFR §413.232. Low-volume adjustment payments made to an ESRD facility that fails to meet the eligibility criteria must be recouped by the ESRD facility's FI or A/B MAC through reprocessing claims paid during the payment year (for CY 2011 and each year thereafter) in which the ESRD facility incorrectly received the low-volume payment adjustment. All payment adjustments should be completed within 6 months of identifying the overpayments. We anticipate the number of ESRD facilities that have received the low-volume payment incorrectly will be limited as few ESRD facilities qualify for the low-volume payment adjustment. An ESRD facility that is subjected to recoupment of low-volume adjustment overpayments as a result of failing to meet the low-volume adjustment eligibility criteria, will not be eligible to receive the low volume payment until it has met the eligibility criteria as specified in 42 CFR §413.232.

To ensure notification to all ESRD facilities of the need to submit the low-volume attestation no later than November 1 of each preceding payment year, November 1st of each year will be the mandatory deadline for the submission of attestations for CY 2012 and each year thereafter for ESRD facilities that believe they are eligible to receive the low-volume payment adjustment.

However, for CY 2012, because the ESRD PPS final rule will not be published in enough time to give the ESRD facilities notification of this mandatory deadline, we are extending the deadline to January 3, 2012. We believe that this process will provide the FI or A/B MACs enough time to perform low-volume eligibility verifications and update the applicable provider specific files for attestations received on or before that date, because the first claim submissions will not occur until early February 2012.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7626.1	Medicare contractors shall perform necessary claim adjustments to rescind the low volume adjustment for providers not meeting the eligibility criteria for the low volume adjustment. All adjustments shall be completed within 6 months of identifying the overpayments.	X		X							
7626.2	Where an audit contractor of the ESRD is not responsible for claims processing of the specific ESRD, the audit contractor should notify the claims processing contractor of that the ESRD is not entitled to the low volume payment, by the implementation date of this CR.	X		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7626.3	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X							

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s):

Policy Michelle.Cruse@cms.hhs.gov 410-786-7540 or
Lisa.Hubbard@cms.hhs.gov 410-786-5472; Claims Processing
Wendy.Tucker@cms.hhs.gov 410-786-3004

Post-Implementation Contact(s):

Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs),* include the following statement:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

20.1 – Calculation of the Basic Case-Mix Adjusted Composite Rate and the ESRD Prospective Payment System Rate

(Rev.2347, Issued: 11-18-11, Effective: 01-01-12, Implementation: 01-03-12)

A case mix methodology adjusts the composite payment rate based on a limited number of patient characteristics. Variables for which adjustments will be applied to each facility's composite rate include age, body surface area (BSA), and low body mass index (BMI). These variables are determined in the ESRD PRICER to calculate the final composite rate (including all other adjustments).

The following table contains claim data required to calculate a final ESRD composite rate and the ESRD PPS rate:

UB-04 Claim Items	**ASC X12N 837i**
Through Date	2300 | DTP segment | 434 qualifier
Date of Birth	2010BA | DMG02
Condition Code (73 or 74)	2300 | HI segment | BG qualifier
Value Codes (A8 and A9) / Amounts	2300 | HI segment | BE qualifier
Revenue Code (0821, 0831, 0841, 0851, 0880, or 0881)	2400 | SV201

For claims with dates of service on or after January 1, 2011, Medicare systems must pass the line item date of service dialysis revenue code lines when the onset of dialysis adjustment is applicable to one or more of the dialysis sessions reported on the claim.

Line Item Date of Service for Revenue Code (0821, 0831, 0841, 0851	2400 | DTP Segment | D8 qualifier

In addition to the above claim data, the following payer only codes are required on claims with dates of service on or after January 1, 2011 to calculate the final ESRD PPS rate:

Payer Only Condition Codes (MA, MB, MC, MD, ME, MF)	2300 | HI segment | BG qualifier
Payer Only Value Code (79)	2300 | HI segment | BE qualifier

Note: These payer only codes above are assigned by the Medicare standard systems and are not submitted on the claim by the provider. Payer only condition codes are only applicable when the appropriate corresponding diagnosis code(s) appears on the claim.

See information below in this section on co-morbidy diagnostic categories. The payer only value code 79 represents the dollar amount for services applicable for the calculation in determining an outlier payment.

The following provider data must also be passed to the ESRD PRICER to make provider-specific calculations that determine the final ESRD rate:

Field	**Format**
Actual Geographic Location MSA	X(4)
Actual Geographic Location CBSA	X(5)
Special Wage Index	9(2)V9(4)
Provider Type	X(2)
Special Payment Indicator	X(1)

In addition to the above provider data, the following is required to calculate the final ESRD PPS rate effective January 1, 2011:

Blended Payment Indicator	X(1)
Low-Volume Indicator	X (1)

Effective January 1, 2012 the following is required to calculate the Quality Incentive Program adjustment for ESRD facilities:

Quality Indicator Field	X(1)

ESRD facilities may elect to be reimbursed 100 percent by ESRD PPS no later than November 1, 2010. Facilities that do not elect to be reimbursed 100 percent by the ESRD PPS will be reimbursed by a blended payment rate which is composed of the current basic case-mix adjusted composite rate payment system and the new ESRD PPS.

Blended payment schedule:

Calendar year 2011 – 75 percent of the old payment methodology and 25 percent of new ESRD PPS payment

Calendar year 2012 – 50 percent of the old payment methodology and 50 percent of the new ESRD PPS payment

Calendar year 2013 – 25 percent of the old payment methodology and 75 percent of the new ESRD PPS payment

Calendar year 2014 – 100 percent of the ESRD PPS payment

Based on the claim and provider data shown above, the ESRD PRICER makes adjustments to the facility specific base rate to determine the final composite payment rate. The following factors are used to adjust and make calculations to the final payment rate:

Provider Type	Drug add-on	Budget Neutrality Factor
Patient Age	Patient Height	Patient Weight
Patient BSA	Patient BMI	BSA factor
BMI factor	Condition Code 73 adjustment (if applicable)	Condition Code 74 adjustment (if applicable)

In addition to the above adjustments, the following adjustments may be applicable to the ESRD PPS base rate for **adult** patient claims with dates of service on or after January 1, 2011:

Onset of Dialysis	Patient Co-morbidities	Low-Volume ESRD Facility

Onset of Dialysis:

Providers will receive an adjustment to the ESRD PPS base rate for patients within the first 4 months of dialysis treatment. The provider does not report anything on the claim for this adjustment. The adjustment is determined by the start date of dialysis in the Common Working File as reported on the patient's 2728 form. When the onset of dialysis adjustment is provided, the claim is not entitled to a co-morbidity adjustment or a training add-on adjustment.

Co-morbidity Adjustment Categories

The ESRD PPS will provide adjustments for 6 categories of co-morbidity conditions. Three categories of chronic conditions and 3 categories of acute conditions. **In the event that more than one of the co-morbidity categories is present on the claim, the claim will be adjusted for the highest paying co-morbidity category.**

Acute Co-morbidity Diagnostic Categories:

The acute co-morbidity categories will be eligible for a payment for the first month reported and the following 3 consecutive months. Acute co-morbidity conditions reported for more than 4 consecutive months will not receive additional payment. In the event that the co-morbidity condition was resolved and later reoccurred, the provider may submit a condition code to indicate the diagnosis is a reoccurrence. The adjustment will be applicable for an additional 4 months.

Acute Categories are:

- Gastro-intestinal tract bleeding
- Bacterial pneumonia
- Pericarditis

Chronic Co-morbidity Diagnostic Categories:

When chronic co-morbidity codes are reported on the claim an adjustment may be made for as long as the chronic condition remains applicable to the patient care provided and is reported on the claim.

Chronic Categories are:

- Hereditary hemolytic or sickle cell anemia
- Monoclonal gammopathy
- Myelodysplastic syndrome

Information related to the comorbid conditions eligible for adjustment can be found at the **following website:**
http://www.cms.gov/ESRDPayment/40_Comorbidity_Conditions.asp#TopOfPage. . This list may be updated as often as quarterly in January, April, July and October of each year.

Low-Volume Facilities:

ESRD facilities will receive an adjustment to their ESRD PPS base rate when the facility furnished less than 4,000 treatments in each of the three cost report years preceding the payment year and has not open, closed, or received a new provider number due to a change in ownership during the 3 years preceding the payment year. The ESRD facility must notify their Medicare Contractor if they believe they are eligible for the low-volume adjustment. Contractors must validate the eligibility and update the provider specific file. Pediatric patient claims are not eligible for the low-volume adjustment.

Medicare contractors are instructed to validate the facility's eligibility for the low volume adjustment. If a Medicare contractor determines that an ESRD facility has received the low volume adjustment in error, the contractor is required to adjust all of the ESRD facility's affected claims to remove the adjustment within 6 months of finding the error.

In addition to the above adjustments, the following adjustments may be applicable to the ESRD PPS base rate for **adult and pediatric** patient claims with dates of service on or after January 1, 2011:

Training Adjustment: The ESRD PPS provides a training add-on of $33.44 adjusted by the geographic area wage index that accounts for an hour of nursing time for training treatments. The add-on applies to both PD and HD training treatments**.**

ESRD PPS Outlier Payments:

Outlier payments may be applied to the payment. ESRD outlier services are the following items and services that are included in the ESRD PPS bundle: (1) ESRD-related drugs and biologicals that were or would have been prior to January 1, 2011, separately billable under Medicare Part B; (2) ESRD-related laboratory tests that were or would have been, prior to January 1, 2011 separately billable under Part B; (3) medical/surgical supplies, including syringes, used to administer ESRD-related drugs that were or would have been prior to January 1, 2011, separately billable under Medicare Part B; and (4) renal dialysis service drugs that were or would have been, prior to January 1, 2011 covered under Medicare Part D. ESRD-related oral only drugs are delayed until January 1, 2014. Services not included in the PPS that remain separately payable are not considered outlier services.

When the ESRD PRICER returns an outlier payment, the standard systems shall display the total applicable outlier payment on the claim with value code 17.
Information related to the outlier services eligible for adjustment can be found at the following website: http://www.cms.gov/ESRDPayment/30_Outlier_Services.asp#TopOfPage. This list may be updated as often as quarterly in January, April, July and October of each year.