CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2839	**Date: December 13, 2013**
	Change Request 8472

Transmittal 2831, dated November 29, 2013 is being rescinded and replaced by Transmittal 2839, dated December 13, 2013, to include a business requirement (BR 8472-04.5) to eliminate the transitional budget neutrality adjustment. All other information remains the same.

SUBJECT: Implementation of Changes in the End-Stage Renal Disease Prospective Payment System (ESRD PPS) for Calendar Year (CY) 2014

I. SUMMARY OF CHANGES: This Change Request implements the fourth year of the ESRD PPS 4-year transition period and the CY 2014 rate updates for the ESRD PPS. This recurring update notification applies to Pub. 100-02, Medicare Benefit Policy Manual, Chapter 11, section 50.

EFFECTIVE DATE: January 1, 2014
IMPLEMENTATION DATE: January 6, 2014

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

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
R	8/50.8/Training and Retraining
R	8/60.2.1.2/Facilities Billing for ESRD Drugs and Biologicals Equivalent to Injectable Drugs

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor's 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 obliged 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:

Recurring Update Notification
Manual Instruction

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

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 2839	Date: December 13, 2013	Change Request: 8472

Transmittal 2831, dated November 29, 2013 is being rescinded and replaced by Transmittal 2839, dated December 13, 2013, to include a business requirement (BR 8472-04.5) to eliminate the transitional budget neutrality adjustment. All other information remains the same.

SUBJECT: Implementation of Changes in the End-Stage Renal Disease Prospective Payment System (ESRD PPS) for Calendar Year (CY) 2014

EFFECTIVE DATE: January 1, 2014
IMPLEMENTATION DATE: January 6, 2014

I. GENERAL INFORMATION

A. Background: In accordance with Section 153(b) of the Medicare Improvements for Patients and Providers Act (MIPPA), The Centers for Medicare & Medicaid Services (CMS) implemented the ESRD bundled Prospective Payment System (PPS) effective January 1, 2011.

CY 2014 implements the fourth year of the transition where all ESRD facilities will be paid 100 percent of the ESRD PPS payment amount. Accordingly, a blended rate of the basic case-mix composite rate payment system and the ESRD PPS will no longer be provided and there will no longer be a transition budget neutrality adjustment factor applied to the payment. Therefore, it is no longer necessary to update the basic case-mix adjusted composite rate payment system.

Section 153(b) was amended by section 3401(h) of the Affordable Care Act, and stated that for 2012 and each subsequent year the Secretary shall reduce the ESRD bundled (ESRDB) market basket increase factor by a productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Social Security Act (the Act). The ESRDB market basket increase factor minus the productivity adjustment will update the ESRD PPS base rate.

Section 1881(b)(14)(I) of the Act, as added by section 632(a) of the American Taxpayer Relief Act of 2012 (ATRA), requires that, for services furnished on or after January 1, 2014, the Secretary shall make reductions to the single payment for renal dialysis services to reflect the Secretary's estimate of the change in the utilization of ESRD-related drugs and biologicals (excluding oral-only ESRD-related drugs) by comparing per patient utilization data from 2007 with such data from 2012.

B. Policy: Calendar Year (CY) 2014 Rate Updates

For CY 2014, CMS will make the following updates to the CY 2013 ESRD PPS base rate:

1. The ESRDB market basket minus a productivity adjustment of 2.8 which results in $247.09 ($240.36 x 1.028 = $247.09).

2. The wage index budget neutrality adjustment factor of 1.000454 which results in $247.20 ($247.09 x 1.000454 = $247.20).

3. The home dialysis training add-on budget neutrality adjustment factor of 0.999912 which results in $247.18 ($247.20 x 0.999912 = $247.18).

4. After the application of the ESRDB market basket, the wage index budget neutrality adjustment factor, and the home dialysis training add-on budget neutrality factor, the ESRD PPS base rate will be reduced by the drug utilization reduction of $8.16. Therefore, the ESRD PPS base rate for CY 2014 is $239.02 ($247.18 - $8.16 = $239.02).

or CY 2014, CMS will make the following updates to the wage index:

1. The wage index adjustment will be updated to reflect the latest available wage data.

2. The wage index floor will be reduced from 0.50 to 0.45.

Transition Budget Neutrality Adjustment

Beginning CY 2014, there will no longer be a transition budget-neutrality adjustment.

Home Dialysis Training Add-On Payment

The home dialysis training add-on payment will increase from $33.44 to $50.16.

Outlier Policy Changes

For CY 2014, CMS will make the following updates to the adjusted average outlier service MAP amount per treatment:

1. For adult patients, the adjusted average outlier service MAP amount per treatment is $50.25.

2. For pediatric patients, adjusted average outlier service MAP amount per treatment is $40.49.

For CY 2014, CMS will make the following updates to the fixed dollar loss amount that is added to the predicted MAP to determine the outlier threshold:

1. The fixed dollar loss amount is $98.67 for adult patients.

2. The fixed dollar loss amount is $54.01 for pediatric patients.

For CY 2014, CMS will make the following changes to the list of outlier services:

1. The ESRD-related Part D drugs which are based on the most recent prices retrieved from the Medicare Prescription Drug Plan Finder will be updated to reflect the most recent mean unit cost. The list of ESRD-related Part D drugs will also be updated to reflect the most recent list of ESRD-related Part D drugs that are eligible for outlier payment. See attachment A.

2. The mean dispensing fee of the National Drug Codes (NDC) qualifying for outlier consideration is revised to $1.42 per NDC per month for claims with dates of service on or after January 1, 2014. See attachment A.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8472-04.1	Medicare contractors shall load the 2014 ESRD PPS PRICER.								X				
8472-04.2	Medicare contractors shall update the provider file for ESRD facilities as necessary to reflect: 1. Attested low volume facilities if applicable; 2. Revised CBSA codes if applicable; 3. Quality indicator for any applicable QIP adjustments.	X											
8472-04.3	Medicare contractors shall update the Part D outlier drug list and mean unit costs for claims with dates of service in 2014. See Attachment A.								X				
8472-04.4	Medicare contractors shall update the NDC dispensing fee for ESRD outlier services to $1.42 for claims with dates of service in 2014.								X				
8472.-04.5	Medicare contractors shall eliminate the transitional budget neutrality adjustment for claims with dates of service on or after January 1, 2014. (TBNA = 1.00).								X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
8472-04.6	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/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 sites 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 the contractor's 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							

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Wendy Tucker, 410-786-3004 or wendy.tucker@cms.hhs.gov (Claims Processing), Michelle Cruse, 410-786-7540 or michelle.cruse@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

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

Section B: 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.

Attachment

Attachment A

Outlier Services

Oral and Other Equivalent Forms of Injectable Drugs[1]

NDC[2]	Drug Product	Mean Unit Cost
30698014301 30698014323 54868346100	Rocaltrol (calcitriol) 0.25 mcg capsules	$ .72
30698014401	Rocaltrol (calcitriol) 0.5 mcg capsules	$ 2.32
30698091115	Rocaltrol (calcitriol) 1 mcg/mL oral solution (15ml/bottle)	$ *12.61*
00054000725 00054000713 00093065701 43353063381 00440721599 54868458400 63304023901 63304023930 67544103581 *23155011801*[3] *23155011803*[3] *43353003481*[3] *66336085190*[3]	Calcitriol 0.25 mcg capsules	$ *0.79*
00093065801 54868458200 63304024001 *23155011901*[3]	Calcitriol 0.5 mcg capsules	$ *1.50*
00054312041 63304024159	Calcitriol 1 mcg/mL oral solution (15ml/bottle)	$ *9.14*
00074431730	Zemplar (paricalcitol) 1 mcg capsule	$ *10.70*
00074431430	Zemplar (paricalcitol) 2 mcg capsule	$ *21.41*
00074431530	Zemplar (paricalcitol) 4 mcg capsule	$ *42.99*
58468012001	Hectorol (doxercalciferol) 0.5 mcg capsule	$ *2.10*
58468012401	Hectorol (doxercalciferol) 1 mcg capsule	$ *4.19*
58468012101	Hectorol (doxercalciferol) 2.5 mcg capsule	$ *28.04*
54482014407	Carnitor (levocarnitine) 330 mg tablet	$ *0.85*
54482014508	Carnitor (levocarnitine) 1GM/10ML oral solution (118mL/bottle)	$ *0.26*
54482014701	Carnitor (levocarnitine) 1 g/5 mL injection	$ *6.72*
64980050312 50383017104	Levocarnitine 1GM/10ML oral solution (118mL/bottle)	$ 0.20
64980013009 50383017290	Levocarnitine 330 mg tablet	$ *0.63*

[1] Outlier services imputed payment amounts. Oral or other equivalent forms of Part B injectable drugs included in the ESRD PPS bundle (notwithstanding the delayed implementation of ESRD-related oral-only drugs effective 1/1/2014).

[2] The mean dispensing fee of the NDCs listed above is $*1.42*. This amount will be applied to each NDC included fee on the monthly claim. We will limit 1 dispensing per NDC per month. Providers should report the quantity in the smallest available unit. This is necessary because Medicare is using the mean per unit cost in calculating the outlier. For example, if the provider reports NDC 00054312041 Calcitriol 1 mcg/ml oral solution (15/ml/bottle) reported and uses the full 15 ml bottle, the quantity is as 15, not 1. This allows for the most accurate calculation for the outlier.

[3] Effective January 1, 2014, this ESRD-related item or service is eligible for outlier payment and is therefore being added to the list of outlier services.

Laboratory Tests

CPT/HCPCS	Short Description
82108	Assay of aluminum
82306	Vitamin d, 25 hydroxy
82379	Assay of carnitine
82570	Assay of urine creatinine
82575	Creatinine clearance test
82607	Vitamin B-12
82652	Vit d 1, 25-dihydroxy
82668	Assay of erythropoietin
82728	Assay of ferritin
82746	Blood folic acid serum
83540	Assay of iron
83550	Iron binding test
83970	Assay of parathormone
84134	Assay of prealbumin
84466	Assay of transferrin
84540	Assay of urine/urea-n
84545	Urea-N clearance test
85041	Automated rbc count
85044	Manual reticulocyte count
85045	Automated reticulocyte count
85046	Reticyte/hgb concentrate
85048	Automated leukocyte count
86704	Hep b core antibody, total
86705	Hep b core antibody, igm
86706	Hep b surface antibody
87040	Blood culture for bacteria
87070	Culture, bacteria, other
87071	Culture bacteria aerobic other
87073	Culture bacteria anaerobic
87075	Culture bacteria, except blood

87076	Culture anaerobe identify, each
87077	Culture aerobic identify
87081	Culture screen only
87340	Hepatitis b surface ag, eia

Equipment and Supplies

HCPCS	Short Description
A4657	Syringes with or with needle, each
A4913	Miscellaneous dialysis supplies, not otherwise specified

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

(Rev. 2839, Issued: 12-13-13, Effective: 01-01-14, Implementation: 01-06-14)

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-morbidity 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 *have* elect*ed* to be reimbursed 100 percent by ESRD PPS no later than November 1, 2010. Facilities that *did* 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 initial 120 calendar days from when an ESRD beneficiary began their maintenance dialysis. 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 Web site:** 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 3 cost report years preceding the payment year and has not opened, 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 *Add-On Payment*: The ESRD PPS provides a training add-on *payment which is* adjusted by the geographic area wage index. *The payment accounts for* nursing time *and* applies to both PD and HD training treatments. *Updates to the training add-on payment are published through rulemaking.*

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 Web site: 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.

For claims submitted with dates of service on or after January 1, 2012, all drugs reported on the ESRD claim under revenue codes 0634, 0635 and 0636 with a rate available on the ASP file will be considered in the Medicare allowed payment (MAP) amount for outlier consideration with the exception of any drugs reported with the AY modifier and drugs included in the original composite rate payment system.

Value Codes and Amounts

48 - Hemoglobin Reading - Code indicates the most recent hemoglobin reading taken before the start of this billing period. This is usually reported in three positions with a decimal. Use the right of the delimiter for the third digit.

The blood sample for the hemoglobin reading must be obtained before the dialysis treatment. If a hemoglobin value is not available facilities must report the value 99.99.

49 - Hematocrit Reading - Code indicates the most recent hematocrit reading taken before the start of this billing period. This is usually reported in two positions (a percentage) to the left of the dollar/cents delimiter. If the reading is provided with a decimal, use the position to the right of the delimiter for the third digit.

The blood sample for the hematocrit reading must be obtained before the dialysis treatment. If a hematocrit value is not available facilities must report the value 99.99.

50.8 - Training and Retraining

(Rev. 2839, Issued: 12-13-13, Effective: 01-01-14, Implementation: 01-06-14)

See *Pub. 100-02* Medicare Benefit Policy Manual, Chapter 11, for coverage rules for dialysis training.

Training services and supplies that are covered under the composite rate include personnel services, dialysis supplies and parenteral items used in dialysis, written training

manuals, material and laboratory tests. The facility is reimbursed an add-on amount to their composite rate and the amount is dependent on the type of dialysis, as shown below:

0821	Composite Rate	Plus	$20.00
0831	Composite Rate	Plus	$20.00
0841	Composite Rate	Plus	$12.00
0851	Composite Rate	Plus	$20.00

Training

For intermittent peritoneal dialysis (IPD), continuous cycling peritoneal dialysis (CCPD) and hemodialysis training:

> The facility's composite rate (exclusive of any approved exception amount) plus $20 per training session, furnished up to 3 times per week. A facility is not reimbursed for more than three IPD or hemodialysis training treatments in a single week, for a total duration longer than 3 months, unless it has received an exception in accordance with §40 of this chapter. A maximum of 15 CCPD training sessions are reimbursable.

For continuous ambulatory peritoneal dialysis (CAPD):

> The facility's composite rate (exclusive of any approved exception amount) plus $12 per training session. Only one CAPD training session per day is reimbursable, up to a maximum of 15.

Retraining

A. General - Occasionally, it is necessary to furnish additional training to an ESRD self-dialysis beneficiary after the initial training course is completed. Retraining sessions are paid under the following conditions:

- The patient changes from one mode of dialysis to another, e.g., from hemodialysis to CAPD;
- The patient's home dialysis equipment changes;
- The patient's dialysis setting changes;
- The patient's dialysis partner changes; or
- The patient's medical condition changes e.g., temporary memory loss due to stroke, physical impairment.

The patient must continue to be an appropriate patient for self-dialysis.

B. Payment Rates - Retraining sessions are reimbursed at the same rate as the facility's training rate.

C. Duplicate Payments - No composite rate payment is made for a home dialysis treatment furnished on the same day as a retraining session. In the case of a CAPD patient, the facility's equivalent CAPD daily rate is not paid on the day(s) of retraining.

EXAMPLE: A CAPD patient dialyzes at home Monday and Tuesday. On Wednesday he attends a retraining session at his facility. Thursday through Sunday he dialyzes at home. The facility's composite rate is $130 per treatment. The Part B deductible is met. For that week the facility's payment is:

80 percent of:

CAPD weekly rate = 3 X 130 = $390
CAPD daily rate = $390 ÷ 7 = $55.71
CAPD training rate = $130 + $12 = $142
6 X 55.71 = $334.26
+ $142
$476.26

Therefore, for the week Monday - Sunday, payment is 80 percent X $476.26 = $381.01

NOTE: Often, services furnished to a CAPD patient who has already completed a course of training are home support services, and not retraining services. Reviewing the CAPD patient's technique and instructing him/her in any corrections or refinements in technique is a support service; and, therefore, is not covered as a retraining service.

ESRD PPS claims with dates of service on or after January 1, 2011, billing for dialysis training sessions will receive a training add-on *payment which is* adjusted by the geographic area wage index that accounts for nursing time for training treatments. The add-on *payment* applies to both PD and HD training treatments. *Updates to the training add-on payment are published through rulemaking.*

60.2.1.2 – Facilities Billing for ESRD Drugs and Biologicals Equivalent to Injectable Drugs

(Rev. 2839, Issued: 12-13-13, Effective: 01-01-14, Implementation: 01-06-14)

The ESRD PPS includes some drugs and biologicals that are currently paid under Medicare *Part* D when these drugs can be used as equivalents to ESRD-related injectable drugs and biologicals. These drugs may be reported on the renal dialysis facility claim for consideration of outlier payments. For the ESRD-related drugs and biologicals that do not have an assigned HCPCS, effective for dates of services on or after January 1, 2011, ESRD facilities should bill using revenue code 0250 and report the national drug code (NDC). The NDC is reported on the 837i claim transaction in loop 2410 line 03.

CMS will price these drugs based on a plan comparison for consideration in the outlier payment. CMS will maintain a list of these drug categories by NDC. Payment includes a mean dispensing fee *and this amount is updated via Recurring Update Notifications*. This amount will be applied to each NDC included on the monthly claim. *CMS* limit*s* 1 dispensing fee per NDC per month. Providers should report the quantity in the smallest available unit. This is necessary because Medicare is using the mean per unit cost in calculating the outlier. For example, if the provider reports NDC 00054312041 Calcitriol 1 mcg/ml oral solution (15/ml/bottle) and uses the full 15 ml bottle, the quantity is reported as 15, not 1. This allows for the most accurate calculation for the outlier.