DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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- "Medicare Billing Information for Rural Providers and Suppliers", Booklet, ICN 006762, Downloadable

MLN Matters® Number: MM7617 Revised

Related CR Release Date: November 16, 2011

Related CR Transmittal #: R150BP

Related Change Request (CR) #: 7617

Effective Date: January 1, 2012

Implementation Date: January 3, 2012

Implementation of Changes in End Stage Renal Disease (ESRD) Payment for Calendar Year (CY) 2012

Note: This article was revised on November 18, 2011, to reflect the revised CR7617 issued on November 16. In this article, the language of item number 8 on page 6 has been revised and the amounts per treatment shown in items 1 and 2 on page 7 have been revised. The CR release date, transmittal number, and the Web address for accessing CR7617 have been revised. All other information is the same.

Provider Types Affected

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

Provider Action Needed

 STOP – Impact to You

This article is based on Change Request (CR) 7617, which informs Medicare contractors about the changes necessary for ESRD payments for CY 2012.

 CAUTION – What You Need to Know

CR 7617 implements:

- The second year of the ESRD Prospective Payment System (PPS) 4-year transition;
- The calendar year 2012 rate updates for the composite rate portion of the blended payment amount and the ESRD PPS rate; and
- Changes to the outlier policy and consolidated billing requirements under the ESRD PPS.

 GO – What You Need to Do

Be sure billing staff knows of this update.

Background

The Medicare Improvements for Patients and Providers Act (MIPPA), section 153(b), available at http://www.govtrack.us/congress/billtext.xpd?bill=h110-6331 required the Centers for Medicare & Medicaid Services (CMS) to implement an ESRD bundled PPS, effective January 1, 2011. The CY 2011 ESRD PPS final rule, published on August 12, 2010 (75 FR 49030 through 49214) and CR 7064, entitled "End Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Consolidated Billing for Limited Part B Services," implemented the ESRD PPS, which included consolidated billing requirements. The article related to CR 7064 is available at http://www.cms.gov/MLNMattersArticles/downloads/MM7064.pdf on the CMS website.

For CY 2012, in addition to updating the ESRD PPS payment amount, CMS must continue to update the composite rate for purposes of determining the composite rate portion of the blended payment amount during the ESRD PPS 4-year transition (CYs 2011 - 2013). CY 2012 implements the second year of the transition where the ESRD facilities that are receiving payment under the transition will be paid a blended amount that will be based on 50 percent of the basic case-mix adjusted composite payment amount and 50 percent of the ESRD PPS payment amount. ESRD facilities that elected to be reimbursed 100 percent based on the ESRD PPS will continue to be reimbursed 100 percent based on the ESRD PPS payment amount.

The Affordable Care Act, section 3401(h), provided that, for 2012 and each subsequent year, the Secretary of Health and Human Services will reduce the ESRD bundled (ESRDB) market basket increase factor by a productivity adjustment described in the Social Security Act (the Act), section 1886(b)(3)(B)(xi)(II). The ESRDB market basket increase factor reduced by the productivity adjustment will update the composite rate portion of the blended rate and the ESRD PPS payment rate portion of the blended rate under the transition and under the full ESRD PPS.

Transition Budget Neutrality Adjustment

Section 1881(b)(14)(E)(iii) of the Social Security Act requires that an adjustment to payments be made for renal dialysis services provided by ESRD facilities during the transition so that the estimated total payments under the ESRD PPS, including payments under the transition, equal the estimated total of payments that would otherwise occur under the ESRD PPS without such transition. Subsequent to the CY ESRD PPS final rule, CMS published an Interim Final Rule on April 6, 2011 (76 FR 18930), entitled, "Changes in the End-Stage Renal Disease Prospective Payment System Transition Budget Neutrality Adjustment," which revised the ESRD transition budget neutrality adjustment from a 3.1 percent reduction to zero percent for renal dialysis services furnished on April 1, 2011 through December 31, 2011. For CY 2012, CMS will continue to apply a zero percent reduction to both the blended payments made under the transition and payments made under the 100 percent ESRD PPS for renal dialysis services furnished January 1, 2012 through December 31, 2012.

Body Surface Area (BSA) Payment Adjustment

Under the ESRD PPS, CMS retained the BSA case-mix adjustment factor for adult patients from the basic case-mix adjusted composite payment system. For CY 2011, CMS used a national average of 1.84 to compute the BSA for the composite rate portion of the blended payment and a national average of 1.87 for the ESRD PPS. For CY 2012 and in subsequent years, CMS will use one national average of 1.87 for computing the BSA under the composite rate portion of the blended payment during the transition and under the ESRD PPS.

ESRD PPS Outlier Policy

Section 1881(b)(14)(D)(ii) of the Act requires that the ESRD PPS include a payment adjustment for high cost outliers due to unusual variations in the type or amount of medically necessary care. The Code of Federal Regulations (CFR), section 413.237(a)(1), provides that ESRD outlier services are those ESRD-related services that were or would have been considered separately paid under Medicare Part B, or would have been separately payable drugs under Medicare Part D (excluding ESRD-related oral-only drugs), prior to January 1, 2011. A listing of the ESRD PPS Outlier Services is available at

http://www.cms.gov/ESRDPayment/30_Outlier_Services.asp#TopOfPage on the CMS website.

For CY 2012, CMS is making the following policy changes to the ESRD PPS outlier policy:

- Effective January 1, 2012, CMS is eliminating the issuance of a list of former separately billable Part B drugs and biologicals that would be eligible for outlier payments, because of the number of Part B drugs and biologicals that may be considered ESRD-related eligible outlier service drugs,

- For CY 2012, CMS is making two modifications to the computation of the separately billable Medicare Allowable Payment (MAP) amounts used to calculate outlier payments, i.e.:

  (1) Subsequent to the publication of the CY 2011 ESRD PPS final rule, CMS' clinical review of the 2007 ESRD claims used to develop the ESRD PPS revealed that ESRD facilities routinely used alteplase and other thrombolytic drugs for access management purposes. Drugs and biologicals that are used as a substitute for any composite rate drug or are used to accomplish the same effect are covered under the composite rate. CMS has recalculated the average outlier services MAP amounts to exclude these composite rate drugs.

  (2) Subsequent to the publication of the CY 2011 ESRD PPS final rule, CMS learned that testosterone and anabolic steroids may be used for anemia management. Because drugs used for anemia management in ESRD patients were or would have been considered separately billable under Medicare Part B, these drugs would be outlier eligible drugs under CFR, section 413.237(a)(1). Consequently, CMS has recomputed the outlier service MAP amounts to include these drugs.

- In order to compute the outlier payment for laboratory tests, the 50 percent rule is required for the tests that comprise the Automated Multi-Channel Chemistry (AMCC) tests. The AMCC panel tests are identified in the "Medicare Benefit Policy Manual", Chapter 11, section 30.2.2, and an explanation of the 50 percent rule can be found in the "Medicare Claims Processing Manual", Chapter 16, section 40.6. In the interest of administrative simplification, CMS is excluding the AMCC laboratory tests from the definition of eligible outlier services and from the computation of outlier payments. The 50 percent rule would continue to apply to AMCC laboratory tests for classification as either composite rate or separately billable for the purpose of computing the composite rate portion of the ESRD PPS blended payment for ESRD facilities that are receiving payments under the ESRD PPS transition.

- Prior to the ESRD PPS, antibiotics, when used at home by a patient to treat an infection of the catheter site or peritonitis associated with peritoneal dialysis, were considered to be composite rate drugs, and, when used for in-facility patients, they were considered to be separately payable. Therefore, for CY 2011, antibiotics used by home patients were not eligible for outlier payment. CMS does not believe that it is appropriate to have this distinction between how antibiotics are classified as composite rate drugs versus drugs that are separately payable. Therefore, CMS is allowing antibiotics when used in the home to treat an infection of the catheter site or peritonitis associated with peritoneal dialysis to be separately billable under the composite rate portion of the ESRD blended payment amount and eligible for outlier payment for claims with dates of service on or after January 1, 2012.

ESRD-Related Laboratory Tests

In the CY 2011 ESRD PPS final rule, CMS finalized a specific list of routine ESRD-related laboratory tests included as part of consolidated billing (Table F: ESRD-Related Laboratory Tests of the Appendix). CR 7497, entitled, "Independent Laboratory Billing of Automated Multi-Channel Chemistry (AMCC) Organ Disease Panel Laboratory Tests for Beneficiaries who are not Receiving Dialysis for Treatment of End Stage Renal Disease (ESRD)," sunset the requirement for independent laboratories to bill separately for each individual AMCC laboratory test included in organ disease panel codes for ESRD eligible beneficiaries. Because organ disease panels consist of AMCC laboratory tests that are ESRD-related laboratory services, it is important for CMS to ensure that these laboratory tests remain in the ESRD PPS bundle. An article related to CR 7497 is available at http://www.cms.gov/mlnmattersarticles/downloads/MM7497.pdf on the CMS website.

CMS is adding the "Assay of protein by other source," which is identified by the Current Procedural Terminology (CPT) code 84157 to the listing of items and services subject to consolidated billing for the ESRD PPS. This listing can be found at http://www.cms.gov/ESRDPayment/50_Consolidated_Billing.asp#TopOfPage on the CMS website. The "Assay of protein by other source" was a composite rate service under the basic case-mix adjusted composite rate system and, consequently, is considered a renal dialysis service under the ESRD PPS.

ESRD PPS Policy Summary for CY 2012

Calendar Year (CY) 2012 Rate Updates:

For CY 2012, CMS will make the following **updates to the composite rate portion of the blended payment amount** for the second year of the ESRD PPS 4-year transition:

1. The CY 2011 Part D per treatment add-on amount (that is, $0.49) will be added to the CY 2011 composite rate in order to update the Part D amount for CY 2012 ($138.53 + $0.49 = $139.02).

2. The composite rate (with the addition of the CY 2011 Part D per treatment add-on amount of $0.49) will be updated by the ESRDB market basket reduced by a productivity adjustment which results in an increase of 2.1 percent ($139.02 x 1.021 = $141.94). Therefore, the unadjusted composite rate for CY 2012 is $141.94.

3. The drug add-on will remain at zero to the composite rate for CY 2012.

4. The wage index adjustment will be updated to reflect the latest available wage data. The wage index is available at http://www.cms.gov/ESRDPayment/ on the CMS website.

5. The wage index floor will be reduced from 0.6000 to 0.5500, then after applying a budget neutrality adjustment of 1.002830, the wage index floor will be 0.5520 for CY 2012.

6. CMS will use the latest national average (that is, 1.87) to calculate the body surface area (BSA) adjustment for CY 2012 and subsequent years. This indicates that the national average of 1.87 will be used for computing the BSA under the composite rate portion of the blended payment during the transition.

7. CMS will allow an antibiotic when used in the home to treat an infection of the catheter site or peritonitis associated with peritoneal dialysis to be separately billable under the composite rate portion of the ESRD blended payment amount for claims with dates of service on or after January 1, 2012.

8. CMS is including alteplase and other thrombolytic drugs and biologicals used for access management purposes as part of the composite rate drugs, therefore these drugs will not be paid separately under the composite rate portion of the ESRD blended payment amount for claims with dates of service on or after January 1, 2012.

For CY 2012, CMS will make the following **updates to the ESRD PPS base rate and wage index**:

1. The ESRD PPS base rate will be updated by the ESRDB market basket reduced by a productivity adjustment which results in an increase of 2.1 percent ($229.63 x 1.021 = $234.45). Therefore, the unadjusted ESRD PPS base rate for CY 2012 is $234.45.

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

3. The wage index floor will be reduced from 0.600 to 0.550. There will be no application of a budget neutrality adjustment to the wage index floor for the full ESRD PPS payments or for the ESRD PPS portion of the blended payment under the transition.

4. The wage index budget neutrality adjustment factor will be applied to the ESRD PPS base rate subsequent to the application of the ESRDB market basket minus productivity adjustment ($234.45 X 1.001520 = $234.81).

Transition Budget Neutrality Adjustment:

For CY 2012, for the transition budget-neutrality adjustment, CMS will continue a zero percent reduction to all payments made to ESRD facilities; that is, the zero percent adjustment would be applied to both the blended payments made under the transition and payments made under the 100 percent ESRD PPS for renal dialysis services furnished January 1, 2012 through December 31, 2012.

Outlier Policy Changes:

For CY 2012, CMS will make the following updates to the average outlier service MAP amount per treatment:

1. For adult patients, the average outlier service MAP amount per treatments is $78.00.

2. For pediatric patients, average outlier service MAP amount per treatment is $45.44.

For CY 2012, 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 $141.21 for adult patients.

2. The fixed dollar loss amount is $71.64 for pediatric patients.

For CY 2012, CMS will make the following changes to the list of outlier services:

1. All ESRD-related Part B drugs and biologicals will be removed from the outlier list. Therefore, all ESRD-related non-composite rate Part B drugs and biologicals with an ASP rate will be included in the outlier calculation. This includes antibiotics when used in the home to treat an infection of the catheter site or peritonitis associated with peritoneal dialysis.

2. The ESRD-related drugs that had been 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 drugs that had been Part D drugs and are included in the ESRD base rate in CY 2012, will also be updated to reflect the most recent list of ESRD-related Part D drugs that are eligible for outlier payment.

3. The mean dispensing fee of the National Drug Codes (NDC) qualifying for outlier consideration is revised to $1.59 per NDC per month for claims with dates of service on or after January 1, 2012.

4. The AMCC laboratory tests are excluded from the definition of eligible outlier services and will therefore be removed.

Consolidated Billing Changes:

CMS is adding the following organ disease panels (identified by HCPCS) to the list of laboratory items and services subject to consolidated billing for the ESRD PPS for dates of service on or after January 1, 2012:

- 80047 - Basic metabolic panel (Calcium, ionized),
- 80048 - Basic metabolic panel (Calcium, total),
- 80051 - Electrolyte panel,
- 80053 - Comprehensive metabolic panel,
- 80061 - Lipid panel,
- 80069 - Renal function panel, and
- 80076 - Hepatic function panel.

CMS is also adding the “Assay of protein by other source,” which is identified by the CPT code 84157 to the list of items and services subject to consolidated billing for the ESRD PPS effective for dates of service on or after January 1, 2012.

Additional Information

The official instruction, CR 7617, issued to your FIs and A/B MACs regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R150BP.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/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.