

MLN Matters Number: MM4196

Related Change Request (CR) #: 4196

Related CR Release Date: December 2, 2005

Effective Date: January 1, 2006

Related CR Transmittal #: 774

Implementation Date: January 3, 2006

MMA - Implementation of Changes in End Stage Renal Disease (ESRD) Payment for Calendar Year (CY) 2006

Note: This article was revised to contain web addresses that conform to the new CMS website and to show they are now MLN Matters articles. All other information remains the same.

Provider Types Affected

Providers billing Medicare fiscal intermediaries (FIs) for End Stage Renal Disease (ESRD) services

Provider Action Needed



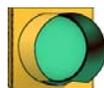
STOP – Impact to You

This article is based on Change Request (CR) 4196, which implements changes in ESRD payment for Calendar Year (CY) 2006.



CAUTION – What You Need to Know

CR4196 makes the following changes to payment to ESRD facilities: 1) Revision to the geographic designation and wage index adjustment applied to the composite payment rate; 2) Revision of the drug payment methodology, moving from acquisition cost pricing to Average Sales Price (ASP) +6 percent; and 3) Revision of the drug add-on adjustment to the composite payment rate as required under MMA.



GO – What You Need to Do

See the *Background* section of this article for further details regarding this change.

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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.

Background

The Social Security Act (Section 1881(b)), as amended by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, Section 623), directed the Centers for Medicare & Medicaid Services (CMS) to make a number of revisions to the composite rate payment system, including payment for separately billable drugs furnished by ESRD facilities. For CY 2006, CMS is making several changes to payment to ESRD facilities and revising the following:

Geographic Designation and Wage Index Adjustment

There are changes to the geographic designation and wage index adjustment applied to the composite payment rate. CMS has revised the geographic classifications using Core-Based Statistical Area (CBSA) designations and wage indexes using the latest hospital data.

In addition, CMS is revising the labor component to which the revised wage index is applied. Beginning January 1, 2006, the labor portion of the composite rate will be 53.711 percent. These changes are being implemented over a four-year transition period. Therefore, for 2006, 75 percent of the wage adjusted composite rate will reflect the old geographic adjustments and 25 percent will reflect the revised adjustments.

Drug Payment Methodology

The drug payment methodology is moving to a single pricing system for all drugs furnished in ESRD facilities using ASP +6 percent pricing. This will allow consistent drug payments for both hospital-based and independent facilities beginning January 1, 2006.

Drug Add-On Adjustment

CMS is revising the drug add-on adjustment to the composite payment rate as required under the MMA. Changes were made to the add-on adjustment to accommodate the new payment methodology and expected growth in ESRD expenditures.

An add-on adjustment of 13.1 percent to the composite payment rate will account for the difference between previous payments for separately billed drugs and biologicals and the revised pricing effective January 1, 2006.

CMS also updated that add-on adjustment to reflect changes in ESRD drug utilization of 1.4 percent. The combined drug add-on adjustment for CY 2006 is 14.7 percent.

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Height and Weight Reporting Requirements for Double Amputee Dialysis Patients

CMS is revising the reporting requirements for the value codes A8 (weight) and A9 (height) applicable to double amputee dialysis patients. For dialysis treatments on or after January 1, 2006, CMS is revising the reporting requirements for value codes A8 (weight) and A9 (height) for double amputee dialysis patients:

- Weight should be calculated based on pre-amputation weight using the following formula: $\text{Pre-amputation weight} = \text{Actual weight} \times 1.5$.
- **Example:** Current weight for double amputee patient = 75.5 kg; Pre-Amputation weight = $75.5 \times 1.5 = 113.3\text{kg}$; the resulting pre-amputation weight should be reported under value code A8. Height should be reported under value code A9 as pre-amputation height. Where feasible, this measurement may be obtained from Form 2728.

Note that CMS is instructing intermediaries to return to the provider any claims where the weight reported in value code A8 exceeds 500kg and/or where the height in A9 exceeds 300cm.

Implementation

The implementation date for the instruction is January 3, 2006.

Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/transmittals/downloads/R774CP.pdf> on the CMS website.

If you have any questions, please contact your intermediary at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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