

New Reporting Requirements

Medicare Claims Processing Manual

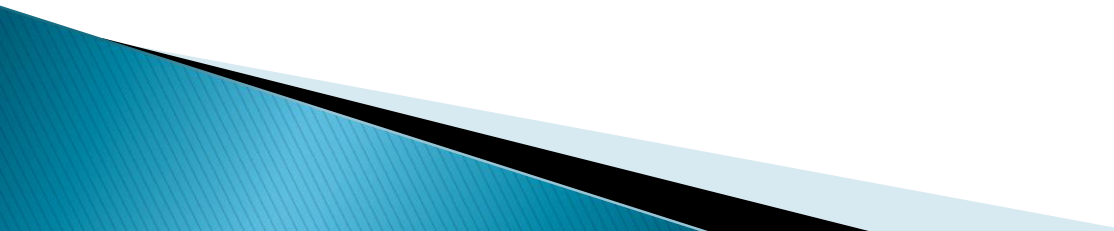
For the implementation of the Medicare
Improvements for Patients & Providers Act (MIPPA)

*Overview by The Renal Network, Inc.
ESRD Network 4, ESRD Network 9 & ESRD Network 10*

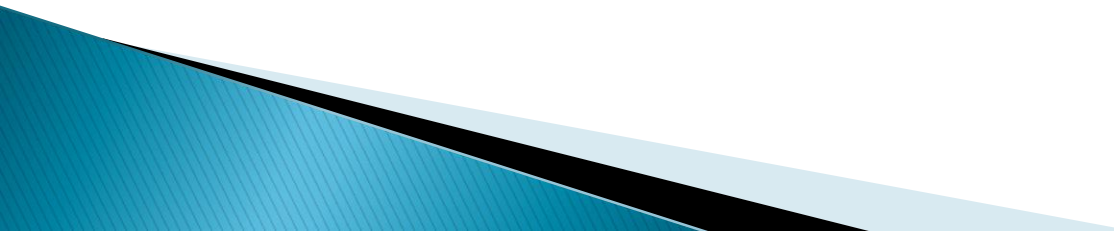
MIPPA = Medicare Improvements for Patients & Providers Act

- ▶ MIPPA requires a quality based payment program for dialysis services.
 - This is the beginning of Pay for Performance (P4P)
 - Payments may be withheld for failure to attain preset goals for specific outcomes
 - Anemia Management
 - Adequacy of Dialysis
 - Vascular Access
- ▶ P4P will be implemented through claims reporting

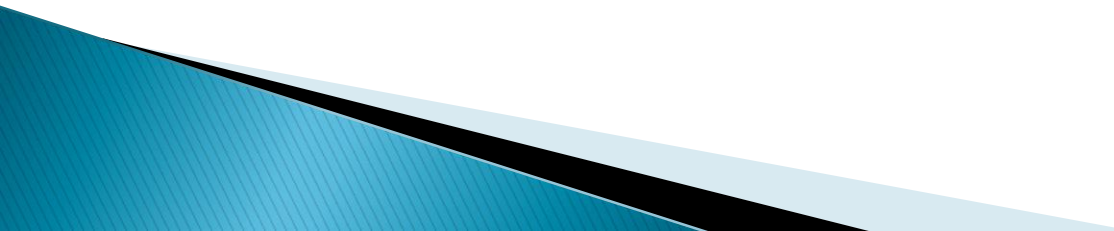
Timeline

- ▶ The quality based payment program – P4P – will take effect on **1/1/2012**.
 - ▶ The claims reporting requirements begin on **7/1/2010**.
 - ▶ This allows CMS to establish baseline data and to begin tracking prior to the actual implementation of P4P.
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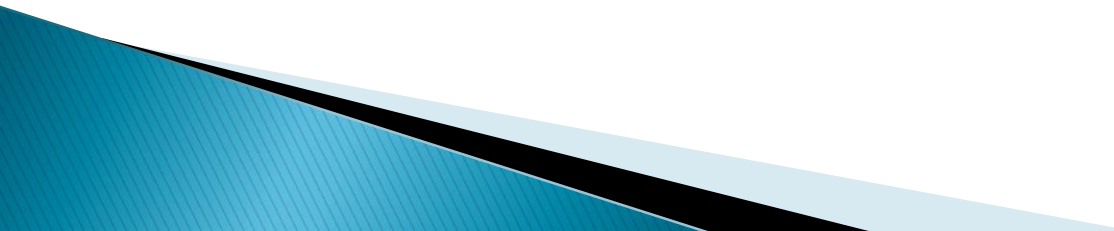
Current Quality Measures

- ▶ The current anemia management quality measure uses the most recent hgb or hct lab value, collected using value codes 48 or 49 on bill type 72x.
 - ▶ The current HD adequacy quality measure uses the current month's URR, collected using HCPCS modifiers G1 through G6.
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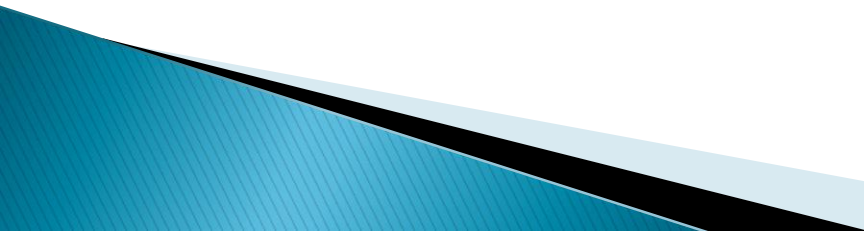
Pros & Cons

- ▶ Anemia Measure is OK & will remain
 - ▶ URR does not report for PD patients
 - ▶ Currently there is no quality measure for vascular access
 - ▶ MIPPA requires that the quality measures must be endorsed by a consensus organization; URR has no endorsement but Kt/V does
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To Meet MIPPA Mandates...

- ▶ CMS will require reporting of Kt/V & date of the reading, vascular access and infection data on ESRD claims with dates of service on or after July 1, 2010.
 - ▶ The new reporting requirement will provide trending data for the January 1, 2012 implementation of P4P.
 - ▶ CMS will require providers to continue to report the existing G1 through G6 modifiers for URR at this time.
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Beginning July 1, 2010:

- ▶ **Value code D5:** Result of last Kt/V reading. For in-center HD, this is the last reading taken during the billing period. For PD and home HD, this may be before the current billing period but should be within four months of the claim date of service.
 - ▶ **Occurrence code 51:** Date of last Kt/V reading. For in-center HD, this is the date of the last reading taking during the billing period. For PD & home HD, this date may be before the current billing period but should be within four months of the claim date of service.
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Beginning July 1, 2010

- ▶ Line level codes to be reported on dialysis revenue code lines:
 - Modifier V8: Infection Present
 - Modifier V9: No Infection Present

Beginning July 1, 2010

- ▶ **Vascular Access:** An indicator of the type of VA used for the delivery of HD at the last HD session of the month. The code is required to be reported on the last line item date of service billing for HD revenue code 0821. (It may be reported on all revenue code 0821 lines at the discretion the provider.)
 - Modifier V5: Catheter
 - Modifier V6: Graft
 - Modifier V 7: Fistula

And Another Thing...

- ▶ The modifiers V5 – V9 are effective January 1, 2010 and the Medicare Integrated Code Editor has been updated to allow the reporting of these codes with dates of service on or after January 1, 2010. Providers may *voluntarily* report these modifiers for claims with dates of service from Jan 1 – July 1, 2010.

For More Information

- ▶ The complete revision to the Manual (Publication 100–04 Medicare Claims Processing) can be found on www.therenalnetwork.org.
- ▶ More information will be sent from the Medicare Fiscal Intermediary directly to the dialysis facilities.