Ensuring Access to Dialysis Care for Acute Kidney Injury Patients Under Traditional Medicare

- Although an issue for over a decade, the provision of dialysis care to individuals with an acute kidney injury (AKI) has emerged as an urgent concern for nephrologists, nephrology nurses and dialysis providers. The catalyst for this urgency was a series of policy clarifications published by the Centers for Medicare and Medicaid Services (CMS) in April and July 2012, explaining that dialysis unrelated to end stage renal disease (ESRD) is covered under the Outpatient Prospective Payment System (OPPS).

- As background, hospitals have typically sought to have AKI patients discharged from the inpatient setting when the only reason for maintaining the individual in the hospital was to receive dialysis treatments. Medicare will only reimburse ESRD facilities, the primary Medicare provider/supplier with specific expertise in dialytic therapy, for treatment of beneficiaries with ESRD. Thus no pathway existed for ESRD facilities to be reimbursed by Medicare for providing these services.

- Over the past decade or more, many hospitals arranged for these services to be provided in outpatient ESRD facilities, billed Medicare, and paid the facilities according to contract terms. A letter from CMS in 2003 encouraged such arrangements.

- Earlier this year, CMS began the process of clarifying how outpatient dialysis for AKI patients is covered under Medicare. First, the Calendar Year 2012 Hospital Outpatient Prospective Payment System final rule issued on November 30, 2011 clarified that the agency was interpreting Section 410.27 of their regulations more broadly to include dialysis, radiation therapy, and other medical services in their definition of outpatient therapeutic services. In April, the Agency issued Change Request (CR) #7762 and a MedLearn Matters Fact Sheet, stating `that for a hospital outpatient who does not have ESRD and is receiving hemodialysis in the hospital outpatient department, the service should be reported on a type of bill 13X or type of bill 85x under the Outpatient Prospective Payment System, using HCPCS code 90935 (Hemodialysis procedure with single physician evaluation).

- The publication of CR 7762 was followed in July 2012 by the issuance of a question-and-answer document that included the following paragraph: ***ESRD facilities cannot furnish acute dialysis to hospital outpatients.*** *The Medicare regulations provide that all therapeutic services furnished to hospital outpatients, whether directly or under arrangements, must be furnished in the hospital or in locations that qualify as provider-based departments of the hospital (42 CFR 410.27(a)(1)). Our regulations prohibit ESRD facilities from being provider-based departments of hospitals (CFR §413.65(a)), and while an ESRD facility may be located on a hospital's campus and may share certain overhead costs and administrative functions with the hospital, CMS does not consider it to be part of*

the hospital. ***Therefore, a hospital may not enter into an arrangement with an ESRD facility for the ESRD facility to provide, outside of the hospital, outpatient dialysis or any other therapeutic service for which the hospital would bill Medicare.*** (Emphasis added). The sum result of these policy clarifications/changes is that the multitude of arrangements nationwide that allowed AKI outpatients to be dialyzed in ESRD facilities are now prohibited.

- In response, an informal coalition of nephrologists, dialysis providers, nephrology nurses, renal administrators, and others brought the matter to the attention of appropriate CMS staff. The group communicated that the policy is not in the best interest of these beneficiaries as it eliminates the most efficient and clinically appropriate setting of care and, in many cases, forces the patient to travel much farther distances to receive care.

- At this point CMS is enforcing a policy that has not been clearly understood by most hospitals. The Agency believes they have educated the hospitals by issuing the information mentioned previously, is inviting complaints and concerns from the physicians and beneficiaries who are affected by the policy, and intends to monitor this issue.

- To that end, CMS is recommending that any concerns about this be referred to the Medical Directors of the local Medicare Administrative Contractors (MACs). Here is a link to the 15 MACs and their medical directors: http://www.cms.gov/medicare-coverage-database/indexes/contacts-part-b-medicare-administrative-contractor-index.aspx?bc=AgAAAAAAAAAA&

This information was developed by representatives of:

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