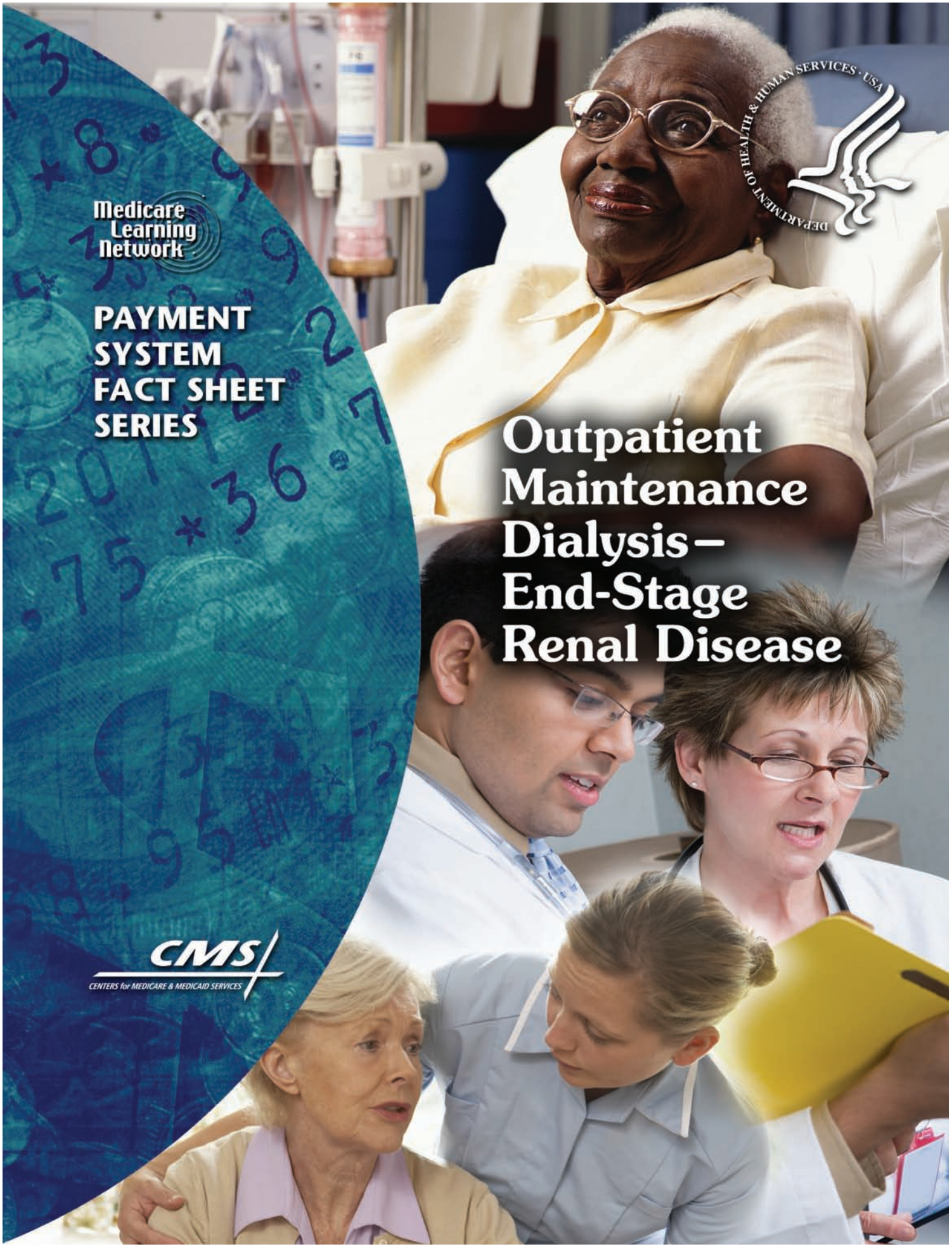

Medicare Learning Network
PAYMENT SYSTEM FACT SHEET SERIES
Outpatient Maintenance Dialysis–End-Stage Renal Disease
DEPARTMENT OF HEALTH & HUMAN SERVICES · USA
CMS
CENTERS for MEDICARE & MEDICAID SERVICES

The End-Stage Renal Disease (ESRD) Medicare payment for dialysis services is based on a fixed amount known as the composite rate. The composite rate provides a single payment amount that includes the cost of some drugs, laboratory tests, and other items and services furnished to Medicare patients who are receiving dialysis. In addition to payment for the composite rate, separate payment is made for certain laboratory tests and drugs.

COMPOSITE PAYMENT RATE SYSTEM

The composite payment rate system is a prospective comprehensive payment system that covers the bundle of services, tests, certain drugs, and supplies routinely required for dialysis treatments furnished to Medicare patients in approved ESRD facilities. All modes of in-facility and Method I home dialysis are included under the composite payment rate system with the exception of:

- Physician's professional services;
- Separately billable laboratory services; and
- Separately billable drugs.

Under Method I, the facility with which the patient is associated assumes responsibility for furnishing all home dialysis equipment, supplies, and support services. A certified hospital-based outpatient dialysis facility that is not the patient's usual facility can furnish maintenance services and must bill Medicare directly for these services.

Medicare patients pay a 20 percent copayment for composite rate services.

Composite Rate Covered Items and Services

In general, all items and services necessary for delivering outpatient maintenance dialysis are included in the composite rate including routinely provided drugs, laboratory tests, and supplies for dialysis-related services. Services must be furnished by the facility either directly or under arrangement.

Composite Rate Payment Methodology Including Adjustment Factors

The composite rate:

- Is applied on a per-treatment basis, with payments capped at an amount equal to three dialysis sessions per week;
- Is applicable to both facility and home dialysis patients;
- Includes a budget neutral basic case-mix adjustment. Case mix adjusters include:
  - Age (<18, 18-44, 45-59, 60-69, 70-79, ≥ 80 years);
  - Body surface area; and
  - Body mass index;
- Includes wage indices based on acute hospital and employment data;
- Includes a budget neutral wage index adjustment; and

- Includes a drug add-on adjustment, which accounts for the difference between payments for separately billable drugs and payments based on a revised drug pricing methodology and eliminates the difference between composite payment system costs and payments.

The base composite payment rate is currently $136.68 for hospital-based facilities and $132.49 for independent facilities.

Effective January 1, 2008, the wage index adjustment is based on a blend of 25 percent of the Metropolitan Statistical Area and 75 percent of the Core-Based Statistical Area geographic definitions for purposes of determining urban and rural locales and the wage index floor is set at .75.

Effective January 1, 2008, the drug add-on adjustment to the composite rate is 15.5 percent.

SEPARATELY BILLABLE ITEMS AND SERVICES

In addition to the composite rate, dialysis facilities may receive additional payment for separately billable laboratory tests and drugs.

Separately Billable Laboratory Tests

Separately billable laboratory tests are paid according to the Clinical Laboratory Fee Schedule. If separately billable laboratory tests are furnished more often than specified, they are only covered if the medical necessity of the test(s) and the nature of the illness or injury (diagnosis, complaint, or symptom requiring the performance of the test(s)) are included on the claim.

Medicare patients do not pay a copayment for separately billable laboratory tests.

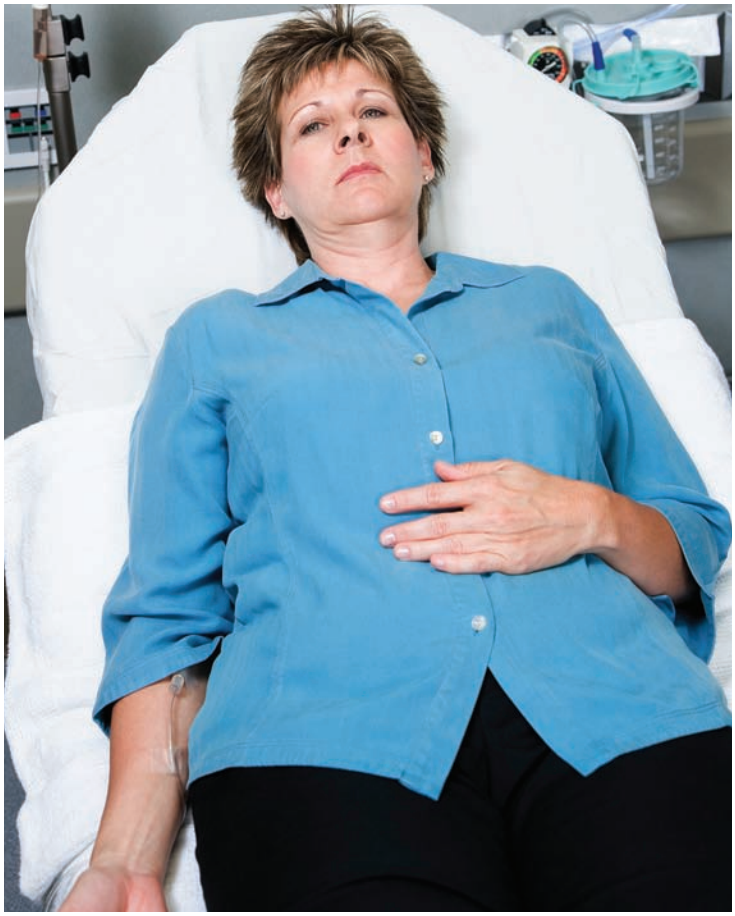
Separately Billable Drugs

Some drugs administered in the facility by facility staff, which are not covered under the composite rate and may be medically necessary for some patients who receive dialysis, must also be billed separately and accompanied by medical justification either through information on the claim form or as requested by the Fiscal Intermediary or A/B Medicare Administrative Contractor. Staff time used to administer the drugs is covered under the composite rate. Supplies used to administer the drugs may be billed in addition to the composite rate.

Hospital-based facilities and independent ESRD facilities are paid the Average Sales Price of drugs plus six percent for separately billable drugs.

Medicare patients pay a 20 percent copayment for separately billable drugs.

Additional information about ESRD can be found at **http://www.cms.hhs.gov/ESRDGeneralInformation** and **http://www.cms.hhs.gov/center/esrd.asp** on the Centers for Medicare & Medicaid Services (CMS) website. On February 20, 2008, the ***Report to Congress: A Design for a Bundled End Stage Renal Disease Prospective Payment System*** was released as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and can be accessed at **http://www.cms.hhs.gov/ESRDGeneralInformation/Downloads/ESRDReportToCongress.pdf** on the CMS website.



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The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at **http://www.cms.hhs.gov/MLNGenInfo** on the CMS website.

Medicare Contracting Reform (MCR) Update
In Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) Congress mandated that the Secretary of the Department of Health and Human Services replace the current contracting authority under Title XVIII of the Social Security Act with the new Medicare Administrative Contractor (MAC) authority. This mandate is referred to as Medicare Contracting Reform. Medicare Contracting Reform is intended to improve Medicare's administrative services to beneficiaries and health care providers. All Medicare work performed by Fiscal Intermediaries and Carriers will be replaced by the new A/B MACs by 2011. Providers may access the most current MCR information to determine the impact of these changes and to view the list of current MACs for each jurisdiction at **http://www.cms.hhs.gov/MedicareContractingReform** on the CMS website.

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