CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 4010	**Date: March 23, 2018**
	Change Request 10541

SUBJECT: Revisions to Medicare Claims Processing Manual for End Stage Renal Disease

I. SUMMARY OF CHANGES: This Change Request (CR) revises the instruction found in the Medicare Claims Processing manual for end stage renal disease.

EFFECTIVE DATE: June 26, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 26, 2018

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	8/40.6/Responsibility of A/B MACs (A)

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

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I. GENERAL INFORMATION

A. Background: This Change Request (CR) revises the instruction found in the Medicare Claims Processing Manual for End Stage Renal Disease.

B. Policy: The purpose of this Change Request (CR) is to revise the policy found in Publication 100-04, Chapter 8, Section 40.6 of the Medicare Claims Processing Manual.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10541.1	Medicare contractors shall be aware of revisions to Section 40.6 - Responsibility of A/B MACs (A) of the Medicare Claims Processing manual.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Tracey Mackey, Tracey.Mackey@cms.hhs.gov , Shauntari Cheely, Shauntari.Cheely@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 8 - Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims

Table of Contents
(Rev.4010, Issued: 03-23-18)

40.6 - Responsibility of A/B MACs (A)

(Rev.4010, Issued: 03-23-18, Effective: 06-26-18, Implementation: 06-26-18)

All pediatric composite rate exception requests are to be reviewed and processed within 15 working days from the date that the exception is filed. The A/B MAC (A) must verify that the exception request contains documentation to support the renal facility's position. When the renal facility fails to submit the required documentation, the exception request is returned to the facility. The 60 working days start when a pediatric renal facility files an exception request with all required documentation with the A/B MAC (A) during the A/B MAC (A)'s regular business hours.

A - Inform CMS central office of pediatric composite rate exception requests

To track the start of the 60 working day requirement, A/B MACs (A) must call CMS central office the day a pediatric composite rate exception is received. The contact person is listed on telephone number (410) 786-5472. The following information is provided:

- The name and provider number of the pediatric renal facility;
- The date the exception is received;
- The type of exception, e.g., pediatric patient mix;
- The amount requested;
- A phone number and contact person at the A/B MAC (A).

B – Composite rate exception log

- The A/B MAC (A) maintains a composite rate exception log. The purpose of this log is to monitor the 15 working days and to ensure the timely processing of all pediatric composite rate exceptions. In addition, the log documents the starting date for processing composite rate exceptions. This is in case a renal pediatric facility alleges that its composite rate exception was not processed within 60 working days. The following information is included in the log:

- The date the exception is received by the A/B MAC (A). (The A/B MAC (A) date stamps each request.);

- The renal pediatric facility's reason for requesting the exception;

- The A/B MAC (A)'s reason for returning the exception;

- The A/B MAC (A)'s recommendation to either approve or deny the facility's request. (All workpapers supporting the A/B MAC (A)'s decision must accompany the facility's exception request when mailed to CMS central office.); and

- The date the exception is mailed to CMS central office.

C – A/B MAC (A) review

The following procedures are applied after receiving a facility's pediatric composite rate exception request:

- The A/B MAC (A) reviews the exception request, the cost report, the facility's projected costs, and any other documentation submitted by the facility to assure that it is complete and accurate. If the renal facility fails to submit the required documentation, the exception request is returned to the facility.

- Mailing of the exception request. After completing its review of the renal facility's exception request, the A/B MAC (A) mails the facility's exception request plus its recommendation with all its supporting work papers to CMS central office. To expedite the exception process, the A/B MAC (A) mails all exception requests using an overnight delivery service. In its cover letter, the A/B MAC (A) must state the date the exception request was received in its office.

- Determination of reasonable and allowable costs. The A/B MAC (A) determines that Medicare principles of reimbursement were used to ensure that only reasonable and allowable costs are included in the facility's costs. The facility reviews the following reimbursement areas:

  1. Bad Debts--Facilities are not to include an allowance for doubtful accounts in reported costs but submit separately the total dollar amount of bad debts actually incurred. Allowable bad debts include only uncollectible deductibles and coinsurance related to covered composite rate services furnished to Part B beneficiaries. Renal facilities may not claim the 50 cents reduction required by §9335(j) of OBRA 1986 as an expense on their Medicare cost reports. The A/B MAC (A) verifies that renal facilities have properly treated this 50 cents reduction before the facility calculates it reimbursable bad debts or files for an exception request. (See §§300 and 2714.)

  2. Allowable Compensation for Physician Owners and Medical Directors— *Prior to January 1, 2016, c*ompensation, including fringe benefits, paid to a physician owner or medical director *could* not exceed the reasonable compensation equivalent (RCE) limits currently in effect for a specialty of internal medicine for a metropolitan area of greater than one million people. *Section 2182 of the Provider Reimbursement Manual described* the RCE. The physician's salary reported as a Medicare allowable cost for administrative services *could not* exceed the RCE limit. Furthermore, the facility *must have adjusted* the RCE limit by the time spent by the physician as owner or medical director performing administrative services for the facility. Based on Medicare program statistics, the median amount of time spent by physicians in ESRD facilities on administrative duties is 25 percent. If a facility reports that a physician spends more than 25 percent of his or her time performing administrative type services, the facility must document its claim. If no documentation is furnished and the facility is reporting physicians' time in excess of 25 percent, the A/B MAC (A) limits the physician's compensation to the lower of the amount claimed or 25 percent of the RCE limit in effect. If the physician as owner or medical director furnishes services to more than one facility, his or her total time may not exceed 25 percent unless the facility has documentation to support its claim. A renal facility may adjust the 25 percent limit to reflect special facts or circumstances, e.g., a medical director may spend more time at a renal facility that furnishes a large number of treatments and other medical services than most renal facilities. If a renal facility claims a higher percentage of time, it must be able to document the medical director's actual time spent performing administrative duties.

     Effective January 1, 2016, the RCE limit for reporting an ESRD facility's medical director fees on ESRD facility cost reports is no longer applicable. However, the A/B MAC (A) may continue to request physician's logs and other documentation as support for the information reported in the cost report.

  3. Allowable Compensation for Owners, Administrators, and Assistant Administrators—- Reasonable compensation, including fringe benefits, paid to owners, administrators, and assistant administrators is an allowable cost. (See §904.) In most instances, compensation paid to these individuals may not exceed $120,000. When these individuals spend less than 100 percent of their time performing services, adjust the $120,000 to reflect the actual time spent at the facility. If an individual provides services to more than one renal facility, the individual's time must be prorated among the different entities and may not exceed 100 percent. In certain circumstances, a renal facility could claim more than the $120,000 limit, e.g., it may be reasonable for a renal facility furnishing a large volume of dialysis treatments and other medical services to pay an

individual in excess of $90,000. In these circumstances, an A/B MAC (A) may survey other renal facilities to determine if the higher amount is reasonable.

4. Depreciation--An appropriate allowance for depreciation on building and equipment is an allowable cost. Payment for services includes depreciation on all depreciable type assets that are used to provide covered services to beneficiaries. (See §104.)

5. Start-up and/or Organizational Costs--Start-up and organizational costs are allowable costs under the program. The start-up and organizational costs incurred must be amortized over an appropriate period of time. (See §2132.)

6. Interns and Residents--Reasonable costs for an approved intern and resident teaching program, if comparable to the costs of other similar facilities that have educational programs, are reimbursable to the hospital under the program. (See §404.)

7. Nursing School--An approved nursing education program must be operated by a provider (or jointly by a group of providers) for students of the provider(s) for Medicare to recognize the costs of the program as allowable costs of the provider(s). (See §404.)

8. Medical Records--The reasonable cost of medical records is reimbursable under the program.

9. Cost to Related Organizations--This cost represents the cost applicable to services, facilities, and supplies furnished to the facility by organizations related to the facility by common ownership or control and is included in the allowable cost of the facility at the cost to the related organization. (See §1005).

10. Home Office Costs—These costs directly related to those services performed for individual facilities which relate to patient care plus an appropriate share of indirect costs (overhead, rent, administrative salaries, etc.) are allowable to the extent they are reasonable. (See §2150.)

11. Prudent Buyer--Facilities are to utilize the prudent buyer concept by refusing to pay more than the going price for an item or service. This is especially so when the buyer is an institution or organization which makes bulk purchases and can, therefore, often obtain discounts because of the size of its purchases. (See §2103.)

12. Dietary--Facilities are not to include the cost of meals served to patients in the outpatient renal department in their reported total costs. However, the reasonable cost of dieticians' salaries is reimbursable under the program.

- Cost Report Review--The A/B MAC (A) performs a limited review of the cost reports prior to submitting to CMS.

    1. The A/B MAC (A) reviews all the cost reporting forms and information submitted in accordance with CMS Pub.15-II to ensure that all the applicable items have been properly completed. All cost reporting forms must be completed. Those items not applicable are submitted and annotated as N/A (not applicable).

    2. The A/B MAC (A) identifies changes in the CPT, lists the requested CPT by modality (i.e., hemodialysis, peritoneal dialysis, and home program), and compares this data with the CPT in the most current cost report. Then, the A/B MAC (A) determines whether the facility has adequately explained any variances in its narrative documentation.

    3. The A/B MAC (A) performs a clerical review by cross footing cost item columns.

- Submission of Documentation--The A/B MAC (A) submits the exception request, a preliminary recommendation, including appropriate workpapers and the reason for the decision, and the cost report and supporting documentation to the following address:

  Centers for Medicare and Medicaid Services
  Centers for Medicare Management
  Chronic Care Policy Group
  Division of Chronic Care Management
  7500 Security Boulevard
  Baltimore, Maryland 21244-1850

  To provide that all filings by the provider are handled by the A/B MAC (A), the A/B MAC (A) instructs the provider to:

  - Mail all exceptions separately from any other material, e.g., Medicare cost reports that are not related to exception requests, and

  - Use specially marked envelopes to forward the exception to the A/B MAC (A).