

## **CHANGES, CLARIFICATIONS AND CONTINUING REVISION OF EPO REIMBURSEMENT RULES FRUSTRATE DIALYSIS COMMUNITY**

Last year the Centers for Medicare and Medicaid Services (CMS) instituted a new policy for the reimbursement of EPO for ESRD patients: If the end of month hematocrit value was greater than 39% (or hemoglobin value was greater than 13 g/dl) the succeeding doses (in the next month) are to be reduced by at least 25% and acknowledged by the caregiver with a “GS” modifier. In absence of this indication, payment would be reduced for the amount given by 25%.

This rule became even more complicated when the industry requested the definition of “dose”. Initially, it was understood that for CMS the “dose” would be the total amount of EPO administered during the previous month – the monthly dose. However, because a patient can have a different number of treatments in a given month, comparing monthly total doses would not be accurate. As a result, CMS modified its approach to be based on a per treatment average dose, and the GS modifier was an acknowledgement by the provider that they had reduced the per treatment dose by 25% in accordance with the CMS regulation. However, under these rules, there is only one spot on the claim form for the GS modifier. So if most, but not all, of the doses had been reduced the presence of the GS modifier on the claim could be interpreted as acknowledgement that all dosing was compliant with the rules.

The anxiety in the provider community was that absent any feedback from fiscal intermediaries (FIs), such as contested claims, the provider was attesting that they were in compliance with the rule without knowing exactly how the rule was going to be interpreted. An added concern was that rule interpretation could be determined by CMS long after the clinic added the GS modifier to the claim.

These reimbursement rules, as in the past, dictated details of clinical practice that can contradict with medical judgment and/or necessity. It is also not clear how CMS and its FIs can or will monitor this compliance. The data sent earlier this year to the Medicare FIs consisted of total EPO administered during a given number of treatments. It would be possible for the FI to calculate the average dose, but it would not be possible to determine if each treatment was in compliance in the absence of an audit.

As this newsletter is going to print, the new rule says the caregiver will attest to the required reduction of each treatment. However, it is not clear, for example, if there is some variability in dosing, but with average EPO dosing in compliance, if the GS modifier can be used.

An overlapping regulation is the tracking of the serial hematocrit/hemoglobin levels, month to month. Starting in January, 2008, added modifiers will be required for high hematocrit/hemoglobin patients: for a patient with monthly hematocrits over 39% (or hemoglobins over 13 g/dl) for three consecutive months, an “ED” modifier will be required; for a patient with at least one monthly hematocrit over 39% (or hemoglobin over 13 g/dl) an “EE” modifier will be required. Patients with hematocrits less than 39% (or hemoglobins less than 13g/dl) during the three months will not need a modifier. These averages must be re-computed each month and the appropriate modifier applied to the Medicare claim.

One suspects that CMS put forth the EPO regulations to control what they considered excessive use of this expensive medication. Their approach was to introduce payment rules that would reign in aggressive dosing of this drug by establishing rules for “allowable” doses based on the patient’s measured hematocrit or hemoglobin. The regulations, however, are too vague for precise implementation of the rules by providers. FIs are apparently ill-prepared or reluctant to offer providers guidance regarding their interpretation. Providers are naturally concerned that interpretations can change after they have faithfully attempted to work within the regulations. This has in turn led to urgent requests for systems and software changes to guard against a future charge of not complying with the rules. In this atmosphere there is considerable frustration, paranoia, and extra effort on the part of providers and their suppliers to conform to regulations that have yet to be completely defined.

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### QMS Focus and QCS:

#### Fully Integrated Renal Management System

#### ACCOMPLISHED DIALYSIS NURSE TO HELP CLIENTS WITH CLINICAL SYSTEM

To add depth and medical expertise to the staff of our fully integrated clinical information system, QCS, we have hired Shirley Blethen, RN, CNN, to help rollout this clinical system to QMS clients. Shirley has over 25 years of experience in a wide range of dialysis related positions: hospital based dialysis programs; senior nurse in both FMC and RAI dialysis facilities; and renal case manager with Renaissance Health Care.

With this extensive experience, Shirley will be a valuable resource for our customers as they use QCS to fully automate the clinical side of their dialysis programs. She will be actively involved in training, support, and helping clients and staff understand the value of comprehensive clinical information and the support of quality initiatives.

QCS is a fully integrated clinical information system that interfaces with virtually all aspects of dialysis care: dialysis machines, commercial labs, etc. Of critical importance, QCS uses and populates the Oracle database so that there is seamless integration of information to assure complete billing and revenue capture in addition to improved staff effectiveness and quality care.

QCS is used by a large number of QMS client facilities and this number is growing.



#### Upcoming Events:

- ASN  
Oct. 31-Nov. 5  
San Francisco, CA  
Booth 1442
- Visit our new message board on our website

#### 7 OF THE TOP 10 RENAL PROVIDERS ARE QMS CUSTOMERS

In July, *Nephrology News and Issues* released its 13th annual ranking of the 10 largest dialysis chains. Among their findings was that a majority of growth in 2007 was attributed to mid-sized dialysis chains-those groups with 3,500 patients or less. We're proud to announce that 7 out of the top 10 providers are in fact QMS customers.

1. **Fresenius Medical Care M.A.**
2. **Davita Inc.**
3. Dialysis Clinic Inc.
4. **Renal Advantage Inc.**
5. DSI Renal Inc.
6. **American Renal Associates**
7. Liberty Dialysis LLC
8. **Satellite Healthcare Inc.**
9. **U.S. Renal**
10. **Dialysis Corp. of America**

*Those listed in bold are QMS customers*