Our mission: CDC is a leader in providing patient centered quality care to all individuals with kidney disease.

The Centers for Dialysis Care

David Oppenlander, CPA
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David is the Chief Financial Officer for the Centers for Dialysis Care. David has worked for 21 years in Healthcare, primarily in hospitals and health systems, the last 3 years have been in Dialysis. He was in the Northeast Ohio healthcare market for 9 years starting with St. Vincent Charity Hospital in Cleveland then with Catholic Health Partners. He was in the Northwest Ohio for 7 years with St. Luke’s Hospital in Maumee, near Toledo. David also spent 2 years in Central Illinois with Decatur Memorial Hospital and with the Hospital Sisters Health System based in Eau Claire, Wisconsin. David started as an accountant at St. Vincent Charity Hospital progressing to become the Chief Financial Officer of Allen Memorial Hospital while working with Catholic Health Partners. Since that time David has held the top financial executive positions with each organization he has been associated.

David received his Bachelors of Business Administration from the University of Toledo and a Masters of Business Administration from Bowling Green State University. David is a Certified Public Accountant and a member of the Ohio Society of CPA’s as well as the Healthcare Financial Management Association (HFMA). David is also a board member of the National Renal Administrators Association and co-chairs their finance committee.
Background

- The CDC is the 9th Largest Dialysis Provider in the US
- Employs approximately 550 people
- $75 Million in Revenue, 1,900 patients 275,000 Tx’s
- 18 Facilities (2 Home Care programs)
- Headquartered in Shaker Heights
- CEO Diane Wish has 30 plus years with the CDC
- Partial Physician Ownership, NFP
- Large Foundation
- Executive Team, mix of tenured and new staff
- CNO, Tracy Douglas, Champion of relationship building
Not Accounting staff
Accounting staff
Section 153(b) of the Medicare Improvements for Patients and Providers Act (MIPPA) requires the implementation of a bundled ESRD PPS effective for Medicare outpatient maintenance dialysis services furnished on or after January 1, 2011. The ESRD PPS combines payments for the composite rate and separately billable renal dialysis items and services into a single base rate.

Prior to January 1, 2011, the Composite rate covered labor and facility costs. Drugs and Biologics were separately billable. The ESRD PPS was phased in over 4 years if facilities elected the phase in otherwise the facility was paid the PPS rate effective January 1, 2011 and thereafter. CY 2014 all facilities are now paid the ESRD PPS rate.
The CY 2014 base rate is $239.02 per treatment. The rate consists of a labor (41.737%) and non labor portion (58.263%). The Labor portion is further multiplied by the wage index were the facility is located.

To compute the base rate for a facility in the Cleveland MSA
$239.02 * 41.437% * .9202 (wage index) + $239.02 * 58.263% = $231.06

The base rate is further adjusted by
- Patient-level adjustments for case-mix
- Facility-level adjustments
- A training add-on
- An outlier adjustment
Items covered in the payment bundle


ESRD facilities billing for ANY labs or drugs will be considered part of the bundled PPS payment unless billed with the modifier AY.

Payment for all ESRD-related laboratory tests furnished under the ESRD PPS is made directly to the ESRD facility responsible for the patient’s care. The ESRD facility must furnish the laboratory tests directly or under arrangement and report ESRD-related laboratory tests on the ESRD facility claim (with the exception of composite rate laboratory services).

An ESRD facility must report ESRD-related laboratory services on its claims in order for the laboratory tests to be included in the outlier payment calculation. ESRD-related laboratory services that were or would have been paid separately under Medicare Part B prior to January 1, 2011, are priced for the outlier payment calculation using the Clinical Laboratory Fee Schedule.
ESRD PPS Rate Basics
Items covered in the payment bundle

All drugs and biologicals used for the treatment of ESRD are included in the ESRD PPS and are not separately paid as of January 1, 2011. The drugs and biologicals include but are not limited to:

- Drugs and biologicals included under the composite rate as of December 31, 2010
- Former separately billable Part B injectable drugs;
- Oral or other forms of injectable drugs used for the treatment of ESRD formerly billed under Part D
- Oral or other forms of drugs and biologicals without an injectable form. (Implementation delayed until January 1, 2016.)

You may separately bill using an AY modifier unless the item is listed as always ESRD Related

**NOTE:** Effective January 1, 2012, you may receive separate payment for vancomycin by placing the AY modifier on the claim when vancomycin is furnished to treat non-ESRD related conditions. The facility must indicate the appropriate ICD diagnosis code for which the vancomycin is indicated.

**NOTE:** Effective January 1, 2013, you may receive separate payment for daptomycin by placing the AY modifier on the claim when daptomycin is furnished to treat non-ESRD related conditions. The Facility must indicate the appropriate diagnosis code for which the daptomycin is indicated.
Albumin may have a separate payment as long as not used as a substitute for something covered under the bundle.

Blood, Blood Products and Blood Supplies are paid separately

Immunizations may be billed and paid separately

A note for Home Dialysis, several items are required to be provided, chairs, equipment, etc. The regulations go so far as mentioning if a patient is wheelchair bound and must weigh themselves everyday, the facility must also provide a wheelchair scale.

Occasionally ESRD facilities furnish items and services that are not used for the treatment of ESRD. When this occurs, ESRD facilities can bill separately by using the AY modifier for the appropriate HCPCS codes used for the administration-supply of the non-ESRD related drug and biological. These supplies include:

- A4657: Injection administration-supply charge (includes the cost of alcohol swab, syringe, and gloves) and
- A4913: IV administration-supply charge (includes the cost of IV solution administration set, alcohol swab, syringe, and gloves). A4913 should only be used when an IV solution set is necessary for non-ESRD related drugs or biologicals to be given. Any non-ESRD related equipment or supply billed using the AY modifier will not be considered an eligible outlier service.
Home Dialysis Training

An ESRD facility may bill a maximum of 25 training sessions per patient for hemodialysis training and 15 sessions for CCPD and CAPD. The average training time for hemodialysis patients is based upon 5-hour sessions given 3 times per week.

The patients can be trained in approximately 4 weeks, usually accomplished in sessions of 10-12 hours.

The CAPD training is furnished in sessions that can last up to 8 hours (one session per day) 5 - 6 days per week. Typically, 6 - 8 CAPD exchanges can be performed per day for the purpose of teaching the patient the CAPD technique; however, no specific number of exchanges is required.

Supplemental dialysis may be billed and paid during CAPD training, up to 3.

CCPD training is furnished in sessions of 8 hours per day 5 days per week. Typically, five exchanges can be performed per day to teach the patient the technique; however, no specific number of exchanges is required. Most patients are trained within 2 weeks; however, up to 15 sessions may be covered routinely.

The FI/MAC may allow for more training for medical necessity.
Services can be provided to dialysis patients under the home health benefit as long as the condition that necessitates home health care is not *ESRD-related*. A beneficiary, entitled to Medicare under the ESRD program, is eligible for home health benefits as is any other Medicare beneficiary if coverage conditions are met provided the patient’s condition is not covered by the *ESRD PPS*. This is true even where the primary condition is related to kidney failure. *For example, Medicare will pay for home health care, such as decubitus care or for severe hypotension that is not included in the ESRD PPS.*

If the patient’s terminal condition is not related to ESRD, the patient may receive covered services under both the ESRD benefit and the hospice benefit. Hospice agencies can provide hospice services to patients who wish to continue dialysis treatment.
Payment Adjusters

**Patient Level Adjusters**
- Patient age
- Body surface area
- Low body mass index
- First 4 months of dialysis
- Six comorbidity categories
  - Chronic
  - Acute

**Facility Level Adjusters**
- Low Volume Adjuster
- Outlier payments
## Payment Adjusters

<table>
<thead>
<tr>
<th>Adult Patient-Level Characteristics</th>
<th>Adjustment Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age: 18-44</td>
<td>1.171</td>
</tr>
<tr>
<td>Age: 45-59</td>
<td>1.013</td>
</tr>
<tr>
<td>Age: 60-69</td>
<td>1</td>
</tr>
<tr>
<td>Age: 70-79</td>
<td>1.011</td>
</tr>
<tr>
<td>Age: 80+</td>
<td>1.016</td>
</tr>
<tr>
<td>Body Surface Area</td>
<td>1.02</td>
</tr>
<tr>
<td>Underweight (BMI &lt;18.5)</td>
<td>1.025</td>
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<tr>
<td>Onset of Dialysis</td>
<td>1.51</td>
</tr>
<tr>
<td>Pericarditis</td>
<td>1.114</td>
</tr>
<tr>
<td>Bacterial pneumonia</td>
<td>1.135</td>
</tr>
<tr>
<td>Gastro-intestinal tract bleeding</td>
<td>1.183</td>
</tr>
<tr>
<td>Hereditary hemolytic or sickle cell anemia</td>
<td>1.072</td>
</tr>
<tr>
<td>Myelodysplastic syndrome</td>
<td>1.099</td>
</tr>
<tr>
<td>Monoclonal gammopathy</td>
<td>1.024</td>
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<tr>
<td></td>
<td>In-Facility</td>
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<td>------------------------------------</td>
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<tr>
<td><strong>Hemodialysis</strong></td>
<td>3 per week</td>
</tr>
<tr>
<td><strong>Hemofiltration</strong></td>
<td>3 per week</td>
</tr>
<tr>
<td><strong>Ultrafiltration</strong></td>
<td>3 per week</td>
</tr>
<tr>
<td><strong>Peritoneal Dialysis (e.g., CAPD and CCPD)</strong></td>
<td>HD Equivalent Sessions (Tx days/7*3)</td>
</tr>
<tr>
<td><strong>Intermittent Peritoneal Dialysis (IPD)</strong></td>
<td>3 per Week</td>
</tr>
</tbody>
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Outlier Payments

Everything that was separately billable, EPO, Labs, Biologics, prior to the implementation of the ESRD PPS is included in the calculation for outlier payments. It is estimated that 1% of total payments are outlier payments. CMS is currently paying less than 1%. The payment is to account for high cost cases, these payments rarely if ever cover the full cost of an outlier case.
Medicaid payments differ by state. Ohio currently pays a composite rate and reimburses for drugs, biologics and other supplies separately.

Dual Eligible Pilot-MyCare Plans
Medicare Cost report considerations

Bad debts are separately reimbursed if applicable on the Medicare Cost Report,
2013 88%
2014 76%
2015 and after 65%

Disallowed Costs
Medical Director costs above RCE Limits
Marketing Expense
Network Fees
Other Costs
Collaboration 1

• Clinical information needs to be complete and signed before treatments are posted
• This delayed billing process by 5-7 days
• Tracy worked with Facility Managers to post treatments (pressure), along with Finance developing an unposted treatment report to review open treatments.
• Current delay is less than a day
• Translated into Finance Terms, this is between $750K TO $1.0 Million in AR
Collaboration 2

- CDC lacked the proper documentation for billing extra Home Care treatments
- Lead by Laurie Rauser or PAD and the Home Care Manager
- Laurie obtained from the F/I the approved diagnosis for extra treatments
- The Home Care Manager ensured proper clinical documentation was in the EMR.
- Supported by Tracy and the Clinical team
- This is still being assessed, estimated to be $200k to 300k per year.
Collaboration 3

- Currently working on Co-Morbids
- Estimated to be $300-$400k per year
- Difficult due to the necessity of reviewing the Hospital IP records