# MEDICARE PART A BULLETIN

April 1, 1997 ESRD Medicare Bulletin E-26

**TO**: All ESRD Medicare Providers

**FROM**: Andy DePirro

**SUBJECT: CALCULATION METHODOLOGY FOR HEMATOCRIT LEVELS USED TO DETERMINE THE APPLICABILITY OF PAYMENT FOR ERYTHROPOIETIN (EPO) PROVIDED TO END STAGE RENAL DISEASE (ESRD) PATIENTS: EFFECTIVE FOR SERVICES PERFORMED ON AND AFTER JULY 1, 1997**

**ATTENTION MEDICARE BUSINESS OFFICE MANAGER:** Please distribute to all appropriate health care facility personnel.

The purpose of this bulletin is notify providers of payment calculation changes to EPO for End Stage Renal Disease (ESRD) patients. This change will affect claims processing for ESRD EPO patients, by applying a new method of payment screening, to safeguard against over utilization.

ESRD patients with symptomatic anemia considered for EPO therapy should be treated until the hematocrit reaches a target range of 30-36%. As the hematocrit level approaches 36%, administration of EPO should be reduced temporarily. The dosage of EPO required to maintain target hematocrit levels is subject to individual patient variation and should be administered (titrated) according to patient response, with a goal of not exceeding a hematocrit level of 36%.

**NEW PROCEDURE**:

Effective for services performed on and after July 1, 1997, the calculation of EPO payments will be based on a 90-day rolling average hematocrit measurement, for ESRD patients whose hematocrit levels are greater than 36%. This new method of calculation will be referred to as the Hematocrit Measurement Audit (HMA). This calculation methodology will be performed on each claim submission with a hematocrit reading exceeding 36%. Intermediaries will continue to utilize value code 49, reported in form locators 39-41 of the HCFA-1450 (UB-92) claims format, to obtain the hematocrit readings.

A 90-day rolling average HMA for ESRD patients whose hematocrit level exceeds 36% will be established. Specifically, a claim containing the most recent hematocrit level exceeding 36% will be averaged with the hematocrit levels posted on all claims for services furnished within the last 90 days.

If claims are submitted out of chronological order, then the HMA calculation will be based on hematocrit level data reported on claims for services furnished 90 days prior to the new (non-sequential) claim submission. If the average of the 90 days of readings is 36.5% or less, EPO is reimbursable.

If the hematocrit level exceeds 36.5%, EPO reimbursement will be denied. This represents a significant change in that previously, Medicare policy provided for payment of EPO for hematocrit levels exceeding 36%, which where supported by medical documentation.

**EXAMPLES OF 90-DAY HMA CALCULATION**

Mary Smith is an ESRD patient who has been receiving EPO therapy for 15 months. She receives her EPO through her ESRD facility, which bills monthly for the EPO. See HMA examples below:

| **CLAIM (MONTH)** | **Hct. Level (%)** | **ACTION** |
|---|---|---|
| March | 38 | HMA calculated |
| February | 35 | EPO reimbursable |
| January | 36 | EPO reimbursable |
| 90-day rolling average | 109/3=36.3 (rounded to 36) | EPO reimbursable March claim |

Since the hematocrit level for March exceeded 36%, the HMA calculation was performed. It was determined that the average hematocrit level did not exceed 36.5%; therefore, the March EPO is reimbursable.

| **CLAIM (MONTH)** | **Hct. Level (%)** | **ACTION** |
|---|---|---|
| April | 38 | HMA calculated |
| March | 38 | EPO reimbursable |
| February | 35 | EPO reimbursable |
| 90-day rolling average | 111/3=37 | EPO denied on April claim |

Since the hematocrit level for April exceeded 36%, the HMA calculation was performed utilizing theprior 90-day rolling average. It was determined that the average hematocrit level exceeded 36.5%; therefore, the April EPO is not reimbursable.

| **CLAIM (MONTH)** | **Hct. Level (%)** | **ACTION** |
|---|---|---|
| May | 35 | EPO reimbursable May claim |

Since the hematocrit level for May did not exceed 36%, the HMA calculation was not performed. The May EPO is reimbursable.

| CLAIM (MONTH) | Hct. Level (%) | ACTION |
|---|---|---|
| June | 37 | HMA calculated |
| May | 35 | EPO reimbursable |
| April | 38 | EPO denied |
| 90-day rolling average | 110/3=36.6 (rounded to 37) | EPO denied on June claim |

Since the hematocrit level for June exceeded 36%, the HMA calculation was performed utilizing the prior 90-day rolling average. It was determined that the average hematocrit level exceeded 36.5%; therefore, the June EPO is not reimbursable.

| CLAIM (MONTH) | Hct. Level (%) | ACTION |
|---|---|---|
| July | 37 | HMA calculated |
| June | 37 | EPO denied |
| May | 35 | EPO reimbursable |
| 90-day rolling average | 109/3=36.3 (rounded to 36) | EPO reimbursable July claim |

Since the hematocrit level for July exceeded 36%, the HMA calculation was performed utilizing the prior 90-day rolling average. It was determined that the average hematocrit level did not exceed 36.5%; therefore, the July EPO is reimbursable.

**NOTE**:If this is a first time claim and the Medicare Contract has no accumulation of claims history, and the hematocrit level on the claim exceeds 36%, then EPO reimbursement will be denied.

In summary, for any given claim, if the hematocrit reading is 36% or less, the HMA will not be performed or applied. If the hematocrit reading is greater than 36%, then the 90-day HMA will be performed , and if the 90-day rolling average hematocrit level is 36.5% or above, reimbursement will be denied.

**REMITTANCE NOTICE MESSAGES**

The following messages will be conveyed on the provider's remittance when the HMA on the claim exceeds 36.5%:

**Claim Adjustment Reason Code**
Value 57: Claim/Service denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage.

**MIA/MOA Remarks Code**
Value MA01: If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the review. However, in order to be eligible for a review, you must write to us within 6 months of the date of this notice, unless you have a good reason for being late.

**NOTE**: The Medicare patient will also be appraised of the coverage decision and any appeal rights, via the Medicare Summary Notice (MSN).

Questions regarding this bulletin may be addressed to the Medicare Part A Customer Service Department by calling (904) 355-8899.