

4007. WORKSHEET S-5 - HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

In accordance with 42 CFR 413.20(a), 42 CFR 413.24(a), and 42 CFR 413.24(c), you are required to maintain statistical records for proper determination of costs payable under the Medicare program. The statistics reported on this worksheet pertain to the renal dialysis department. The data maintained, depending on the services provided by the hospital, includes patient data, the number of treatments, number of stations, and home program data.

If you have more than one renal dialysis department, submit one Worksheet S-5 combining all of the renal dialysis departments' data. You must also have on file (as supporting documentation), a Worksheet S-5 for each renal dialysis department and the appropriate workpapers. File this documentation with exception requests in accordance with CMS Pub. 15-1, chapter 27, §2720. Also enter on the combined Worksheet S-5 the applicable data for each renal dialysis satellite for which you are separately certified (that is, a satellite for which you were issued a satellite CCN).

Section 153(b) of MIPPA amended section 1881(b) of the Act to require the implementation of an ESRD bundled payments system effective January 1, 2011. This new payment system is effectuated on Worksheets I-4 and I-5 (sections 4051 and 4052).

Column Descriptions

Columns 1 and 2--Include in these columns information regarding outpatient hemodialysis patients. **Do not include information regarding intermittent peritoneal dialysis.** In column 2, report information if you are using high flux dialyzers.

Columns 3 through 6--Report information concerning the provider's training and home programs. **Do not include intermittent peritoneal dialysis information in columns 3 and 5.**

Line Descriptions

Line 1--Enter the number of patients receiving dialysis at the end of the cost reporting period.

Line 2--Enter the average number of times patients receive dialysis per week. For CAPD and CCPD patients, enter the number of exchanges per day.

Line 3--Enter the average time for furnishing a dialysis treatment.

Line 4--Enter the average number of exchanges for CAPD.

Line 5--Enter the number of days dialysis is furnished during the cost reporting period.

Line 6--Enter the number of stations used to furnish dialysis treatments at the end of the cost reporting period.

Line 7--Enter the number of treatments furnished per day per station. This number represents the number of treatments that the facility can furnish not the number of treatments actually furnished.

Line 8--Enter your utilization. Compute this number by dividing the number of treatments furnished by the product of lines 5, 6, and 7. This percentage cannot exceed 100 percent.

Line 9--Enter the number of times your facility reuses dialyzers. This number is the average number of times patients reuse a dialyzer. If none, enter zero.

Line 10--Enter the percentage of patients that reuse dialyzers.

Line 10.01--Indicate whether your facility qualified and was approved as a low-volume facility for this cost reporting period. CMS adjusts the base rate for low-volume ESRD facilities. In order to receive this low-volume adjustment, a facility must attest in accordance with 42 CFR 413.232(f). Effective for cost reporting periods ending on or after June 30, 2015, if you operate multiple renal dialysis departments or home program dialysis departments and one of those facilities is eligible for low-volume, respond yes to this question and complete line 23.

Line 10.02--Indicate if your facility elected 100 percent PPS effective January 1, 2011. Enter "Y" for yes or "N" for no. This election must have been received by the ESRD facility's contractor by November 1, 2010. Requests received after this date will not be accepted regardless of postmark or delivery date.

New providers: ESRD facilities certified for Medicare participation on or after January 1, 2011, are paid based on 100 percent of the ESRD PPS payment. ESRD facilities certified for Medicare participation on or after January 1, 2011, enter "Y" for yes.

Line 10.03--If your facility did not elect to be paid based on 100 percent of the ESRD PPS payment and your cost reporting period is a December 31 fiscal year end, enter the transition period in column 2 as follows: For the fiscal year ending December 31, 2011, enter 1; for the fiscal year ending December 31, 2012, enter 2; for the fiscal year ending December 31, 2013, enter 3; and, for the fiscal year ending December 31, 2014, enter 4 for 100 percent ESRD PPS payment. Column 1 will be blank.

If your cost reporting period ends on a date other than December 31, indicate in column 1 the transition period effective for the portion of the cost reporting period prior to January 1. Indicate in column 2 the transition period effective for the portion of the cost reporting period on and after January 1. For example, a cost reporting period with a fiscal year ending October 31 would indicate the applicable transition periods as follows:

Fiscal year ending October 31, 2011: Leave column 1 blank as this would be pre-bundled ESRD PPS, and enter 1 in column 2 for the period of January 1, 2011, through October 31, 2011.

Fiscal year ending October 31, 2012: Enter 1 in column 1 for the period of November 1, 2011, through December 31, 2011, and enter 2 in column 2 for the period of January 1, 2012, through October 31, 2012.

Fiscal year ending October 31, 2013: Enter 2 in column 1 for the period of November 1, 2012, through December 31, 2012, and enter 3 in column 2 for the period of January 1, 2013, through October 31, 2013.

Fiscal year ending October 31, 2014: Enter 3 in column 1 for the period of November 1, 2013, through December 31, 2013, and enter 4 in column 2 for the period of January 1, 2014, through October 31, 2014.

For all cost reporting periods beginning on or after January 1, 2014, enter 4 in column 2 for 100 percent ESRD PPS payment. Column 1 will be blank.

Payments during the transition period 1 are a blend of 25 percent case-mix adjusted ESRD PPS and 75 percent basic case-mix adjusted composite rate (25/75). Payments during the transition period 2 are a blend of 50 percent case-mix adjusted ESRD PPS and 50 percent basic case-mix adjusted composite rate (50/50). Payments during the transition period 3 are a blend of 75 percent case-mix adjusted ESRD PPS and 25 percent basic case-mix adjusted composite rate (75/25). Payments for services rendered on and after January 1, 2014, are 100 percent ESRD PPS.

Line 11--Enter the number of patients who are awaiting a transplant at the end of the cost reporting period.

Line 12--Enter the number of patients who received a transplant during the fiscal year.

Line 13--Enter the direct product cost net of discount and rebates for Epoetin (EPO). Include all EPO cost for patients receiving outpatient, home (Method I or II (claims that would have been processed as Method II are processed as Method I for services rendered on or after January 1, 2011)), or training dialysis treatments. This amount includes EPO cost furnished in the renal department or any other department if furnished to an end stage renal disease dialysis patient. Report on this line the amount of EPO cost included in line 74 of Worksheet A. Effective for cost reporting periods ending after December 31, 2012, do not use this line; report these costs on line 22 (and subscripts), column 2.

Line 14--Based on the instructions contained on line 13, enter the amount of EPO included on line 94 (home dialysis program) from Worksheet A. Effective for cost reporting periods ending after December 31, 2012, do not use this line; report these costs on line 22 (and subscripts), column 3.

Erythropoiesis-Stimulating Agents (ESA) Statistics--Effective January 1, 2005, and prior to January 1, 2011, Medicare paid for ESAs based on the Average Sales Price Drug Pricing File. Effective January 1, 2011, payment for ESAs is included in the ESRD PPS payment.

Line 15--Enter the number of EPO units furnished relating to the renal dialysis department. Effective for cost reporting periods ending after December 31, 2012, do not use this line; report the number of ESA units furnished on line 22 (and subscripts), column 4.

Line 16--Enter the number of EPO units furnished relating to the home dialysis program. Effective for cost reporting periods ending after December 31, 2012, do not use this line; report the number of ESA units furnished on line 22, (and subscripts), column 5.

Line 17--Enter the direct product cost net of discount and rebates for darbepoetin alfa (Aranesp) Include all Aranesp cost for patients receiving outpatient, home (Method I or II (claims that would have been processed as Method II are processed as Method I for services rendered on or after January 1, 2011)), or training dialysis treatments. This amount includes Aranesp cost furnished in the renal department or any other department if furnished to an end stage renal disease dialysis patient. Report on this line the amount of Aranesp cost included in line 74 of Worksheet A. Effective for cost reporting periods ending after December 31, 2012, do not use this line; report these costs on line 22 (and subscripts), column 2.

Line 18--Based on the instructions contained on line 17, enter the dollar amount of Aranesp included on line 94 (home dialysis program) from Worksheet A. Effective for cost reporting periods ending after December 31, 2012, do not use this line; report these costs on line 22 (and subscripts), column 3.

Line 19--Enter the number of micrograms of Aranesp furnished relating to the renal dialysis department. Effective for cost reporting periods ending after December 31, 2012, do not use this line; report the number of ESA units furnished on line 22 (and subscripts), column 4.

Line 20--Enter the number of micrograms of Aranesp furnished relating to the home dialysis program. Effective for cost reporting periods ending after December 31, 2012, do not use this line; report the number of ESA units furnished on line 22 (and subscripts), column 5.

Line 21--Identify how physicians are paid for medical services provided to Medicare beneficiaries. Under the monthly capitation payment (MCP) methodology, contractors pay physicians for their Part B medical services. Under the initial method, the renal facility pays for physicians' Part B medical services. The facility's payment rate is increased in accordance with 42 CFR 414.313. There are a limited number of facilities electing this method.

Line 22--Identify each ESA separately on line 22 and subscripts. Complete this line effective for cost reporting periods ending after December 31, 2012. Enter in column 1, the name of the ESA

administered to renal dialysis patients. Enter in column 2, the direct product cost net of discounts and rebates for ESAs administered to renal dialysis patients. These costs are included in line 74 of Worksheet A. Include all ESA costs for patients receiving outpatient, home, or training dialysis treatments. This amount includes ESA costs furnished in the renal department or any other department if furnished to an end stage renal disease dialysis patient. Enter in column 3 the direct product cost net of discounts and rebates for ESAs administered to home dialysis patients. These costs are included in line 94 of Worksheet A.

Include all ESA costs for patients receiving self-care home dialysis treatments. This amount includes ESA costs furnished in the home dialysis program for an end stage renal disease dialysis patient. Enter in column 4, the total ESA units furnished to renal dialysis department patients during the cost reporting period. Enter in column 5, the total ESA units furnished to home program dialysis patients during the cost reporting period.

Line 23--If line 10.01 is yes, for cost reporting periods ending on or after June 30, 2015, enter on this line, and any applicable subscripts, the CCN and treatments for each renal facility. If this facility operates a renal dialysis facility (CCN XX-2300 through XX-2499), a renal dialysis satellite (CCN XX-3500 through XX-3699), and/or a special purpose renal dialysis facility (CCN XX-3700 through XX-3799), subscript this line and enter in column 1 each CCN from Worksheet S-2, Part I, line 18, and its subscripts. Enter in column 2, the total treatments corresponding to each CCN identified in column 1. The sum of all treatments reported on this line and its subscripts, column 2, must equal the total treatments reported on Worksheet I-4, line 12, column 1, for the renal dialysis department, plus the total treatments reported on Worksheet I-4, line 12, column 1, for the home program dialysis department.