National Government Services

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National Government Services End-Stage Renal Disease Medicare Part A Quick Reference Manual

ESRD Provider PTAN Number Range: Third through sixth digit
2300–2499; 3500–3799 Hospital-based end-stage renal disease (ESRD) facility **2500–2999** Independent ESRD facility **3300–3399** Children's Hospital
FL 04 Type of Bill
072X – where X equals: **1** = one bill – admit through discharge **7** = adjustment to processed claim **8** = void/cancel processed claim
FL 6 Statement Covers Period
From date First date within billing month
Through date Last date within billing month
FL 18-28 Condition Codes
02 Condition is employment-related
04 Information Only Claim **–** Patient is HMO Enrollee
59 Nonprimary ESRD Facility
70 Self-Administered anemia management drugs including Erythropoietin Stimulating Agents (ESAs) and Epoetin Alfa (EPO)
71 Full Care in Unit
72 Self Care in Unit

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73 Self Care Training for home/self-dialysis (Initial training: 25 hemodialysis or 15 peritoneal/CAPD/CCPD dialysis) **Note about initial training sessions allowed:** **Hemodialysis or Intermittent Peritoneal Dialysis (IPD):** Three training treatments in a single week are allowed for a total duration longer than three months, unless an exception has been received. Total of 25 hemodialysis or 15 IPD training sessions are allowed **CAPD/CCPD:** One training session per day with maximum of 15 training sessions
74 Home Dialysis
76 Back up In-Facility dialysis
Note: One of the condition code 71 through 76 apply to each ESRD claim
80 Home Dialysis in SNF (also report condition code 74)
84 Acute Kidney Injury (AKI)
87 Self-care Retraining
FL 18-28 Condition Codes for Comorbidity (Three acute and three chronic)
MA Payer Only – Acute Gastrointestinal (GI) bleed; **do not bill/**system auto-populates when applicable
MB Payer Only – Acute Pneumonia (no longer used); **do not bill/**system auto-populates when applicable
MC Payer Only – Acute Pericarditis; **do not bill/**system auto-populates when applicable
MD Payer Only – Chronic Myelodysplastic syndrome; **do not bill/**system auto-populates when applicable
ME Payer Only – Chronic Hereditary hemolytic and sickle cell anemia category; **do not bill/**system auto- populates when applicable
MF Payer Only – Chronic Monoclonal gammopathy; **do not bill/**system auto-populates when applicable
H3 Reoccurrence of GI Bleed comorbid category (MA)
H4 Reoccurrence of Pneumonia comorbid category (MB)
H5 Reoccurrence of Pericarditis comorbid Category (MC)
Comorbidities: A comorbidity is a specific patient condition that is secondary to the patient's principal diagnosis that necessitates dialysis, yet has a significant, direct effect on resource use during dialysis.

When more than one of the comorbidity categories is present on the claim, the claim will be adjusted for the highest paying comorbidity category

- To qualify for the comorbidity adjustment there must be adherence to diagnosis coding requirements. ICD-10 diagnosis codes are updated annually as stated in the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) Publication 100-04, *Medicare Claims Processing Manual*, Chapter 23, Fee Schedule Administration and Coding Requirements Section 10, are posted on the CMS ICD-10 web page and are effective each October 1st.
- ICD-10 codes eligible for a comorbidity payment adjustment may be updated quarterly
- The most current co-morbidity payment adjustment list and additional information is available on ESRD PPS Patient-Level Adjustments
- Chronic Comorbidity: Adjustment may be made for as long as the chronic condition remains applicable to the patient care provided and is reported on the claim
- Acute Comorbidity: Eligible for a payment for the first month reported and then for the next three consecutive months, regardless of whether or not the diagnosis code is on the claim after the first month. This adjustment applies for no more than four consecutive months for any reported acute comorbidity category.

FL 31-34 Occurrence Codes and Date

24 Date Insurance Denied

33 First Day Medicare Coordination Period for ESRD Beneficiary – Must also bill value code 13

36 Inpatient DC date noncovered transplant

37 Inpatient DC date covered transplant

51 Date of Last Kt/V reading taken during billing period – **all** ESRD claims must include; also report value code D5

- Note: Not required if value code D5 is reported with value of 8.88 or 9.99
- In-center hemodialysis: date during the billing period
- Peritoneal and home hemodialysis: May use date before billing period but must be within four months of claim DOS

FL 35-36 Occurrence Span Code and Date

74 Noncovered Level of Care/Leave of Absence (typically not required for ESRD)

FL 39-41 Value Codes and Amounts

A8 *Weight (dry) of patient (kilograms)

A9 *Height of patient (centimeters)

***Note:** Report measurements taken during last dialysis session of month
D5 Last Kt/V reading result; Required on all ESRD claims; use with occurrence code 51 **Note:** Not required when reporting value code D5 with a value of 9.99 (no Kt/V reading available) or value 8.88 indicating patient was prescribed/received greater than three hemodialysis treatments per week for a medically justified and documented clinical need.
D6 Total number of minutes of dialysis provided during the billing period **Note:** This requirement was withdrawn effective DOS on/after 1/1/2021 (CR 11871 and 12011)
06 Medicare Blood Deductible (Not used when deductible pints replaced)
12 Working Aged Bene/Spouse
13 Primary Payment during 30 Month Coordination Period
14 No Fault
15 Workers' Compensation
16 PHS, or Federal Agency
17 Payer Only – Total outlier from all dialysis lines; **do not bill/**system auto-populates when applicable
19 Payer Only – Total low volume amount for dialysis lines; **do not bill/**system auto-populates when applicable
37 Pints of Blood Furnished
38 Blood Deductible Pints
39 Pints of Blood Replaced
41 Black Lung
42 Veterans Affairs
43 Disabled Bene Under Age 65
44 Contractual Agreement
47 Any Liability Insurance
48 Hemoglobin Reading – Report most recent reading prior to start of billing period

Note: Must report VC 48 and/or 49

- report in three positions with a decimal
- use the right of the delimiter for the third digit
- report 99.99 if no reading was taken

49 Hematocrit Reading – report most recent reading prior to start of billing period

Note: Must report VC 48 and/or 49

- report in three positions with a decimal
- use the right of the delimiter for the third digit
- report 99.99 if no reading was taken

67 Peritoneal Dialysis Hours

68 EPO Units

70 Payer Only – Codes/Interest Amount); **do not bill/**system auto-populates when applicable

71 Payer Only – Total ESRD Network Funding); **do not bill/**system auto-populates when applicable

72 Payer Only – ESRD comorbid Factor; **do not bill/**system auto-populates when applicable

79 Payer Only – Total Medicare Allowed Payment Amount for Outlier Consideration; **do not bill/**system auto-populates when applicable

91 Charges for Kidney Acquisition (effective 10/1/2021 for 11X TOB)

Q8 Payer Only – Total TDAPA amount; **do not bill/**system auto-populates when applicable

QB Payer Only – Total sum of all HDPA bonus amounts; **do not bill/**system auto-populates when applicable

QG Payer Only – Total TPNIES Amount; **do not bill/**system auto-populates when applicable

QK Payer Only – Maryland Waiver Kidney Acquisition Payment (TOB 11X) – **do not bill/payer only**

Important Considerations to Review Prior to Billing

- ESRD PPS Outlier Services

- ESRD PPS Consolidated Billing: ESRD PPS includes Consolidated Billing (CB) requirements for limited Part B services included in the ESRD facility's bundled payment. CMS periodically updates the lists of items and services that are subject to Part B consolidated billing and are therefore no longer separately payable when provided to ESRD beneficiaries by providers other than ESRD facilities.

FL 42 Revenue Codes for Dialysis Drugs
Note: For outlier** consideration ESRD facilities are required to report ESRD-related drugs and biologicals, ESRD-related laboratory tests, and ESRD-related supplies that were or would have been separately payable prior to 1/1/2011. **CMS ESRD PPS Outlier Services
0250 Pharmacy; includes Part D drug equivalent to injectable – National Drug Code (NDC) required
0270 Medical/Surgical Supplies and Devices (HCPCs A4657 and A4913)
0634 EPO less than 10,000 units
0635 EPO 10,000 units or more
Note: Report the number of EPO injections as number of units in FL 46. Report actual total units administered with Value Code 68.
0636 Drugs requiring detailed coding (injectable); enter HCPCS code in FL 44
Note: Number of units, reported in FL 46, should equal the number of times the drug was administered according to current CPT/HCPCS code definition.

Frequency of Dialysis Sessions by Dialysis Modality and Treatment Setting

Note: The ESRD PPS provides a per treatment unit of payment. The per treatment unit of payment is the same base rate that is paid for all dialysis treatment modalities (whether in-facility or home) furnished by an ESRD facility.

- The policy allows for three PPS payments per week.
- For a 30-day month, payment is limited to 13 treatments and for a 31-day month, payment is limited to 14 treatments, with exceptions made for medical justification.
- ESRD facilities billing for more than 13 or 14 treatments per month must provide medical justification as required by National Government Services, Inc. (NGS), your Medicare Administrative Contractor (MAC) in order to receive payment for the additional treatments.
- Additional treatments provided without meeting the medical justification required must include the modifier CG on the claim line to identify that the facility attests the additional treatment does not meet medical justification requirements. Additional treatments billed without medical justification do not receive payment. Noncovered treatments are not considered in the outlier payment calculation.
- This policy does not apply to training/retraining treatments

Service	In-Facility	Home
Hemodialysis (HD)	3 per week	Maximum of 3 per week regardless of frequency Medicare routinely covers 13 HD sessions in 30 day calendar month or 14 sessions in 31 day
Hemofiltration	3 per week	3 per week
Ultrafiltration	3 per week	Maximum of 3 per week, regardless of frequency
Peritoneal Dialysis (PD) – includes, for example, CAPD and CCPD • Typically performed daily	HD-equivalent sessions	HD-equivalent sessions
Intermittent Peritoneal Dialysis (IPD)	3 per week	HD-equivalent sessions
Note: Regardless of dialysis modality or treatment setting, payment for additional treatments may be made when they are medically justified		

Note: Ultrafiltration is not a substitute for dialysis. Ultrafiltration is used in cases where excess fluid cannot be removed easily during the regular course of hemodialysis. It is commonly done during the first hour or two of hemodialysis on patients who, for example, have refractory edema. When used during a regular course of dialysis, ultrafiltration is included in the facility's composite rate. Therefore, no additional charge is recognized for pre-dialysis ultrafiltration.

Resource for above chart: CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 11, Section 50 - ESRD Prospective Payment System (PPS) Base Rate, Item A. Per Treatment Unit of Payment

FL 42 Revenue Codes for Dialysis

082X Hemodialysis

1 Hemodialysis/Composite
5 Support Services

083X Peritoneal Dialysis (PD)

1 Peritoneal/Composite
5 Support Services

084X Continuous Ambulatory Peritoneal Dialysis (CAPD)

1 CAPD/Composite
5 Support Services
9 Other CAPD Dialysis

085X Continuous Cycling Peritoneal Dialysis (CCPD)

1 CCPD/Composite
5 Support Services

088X Ultrafiltration Dialysis

1 Ultrafiltration
9 Hemoperfusion

FL 42 Additional Revenue Codes

0270 Medical Surgical Supplies – General

030X Laboratory

3 Renal Patient (Home) – LAB/RENAL HOME
4 Non-routine Dialysis – LAB/NR DIALYSIS

031X Laboratory – Pathology services

0 General Classification – PATHOLOGY LAB or (PATH LAB)
1 Cytology – PATHOL/CYTOLOGY
2 Histology – PATHOL/HYSTOL

4 Biopsy – PATHOL/BIOPSY

9 Other – PATHOL/OTHER

0390 Blood Processing (blood products)

0399 Blood Storage and Processing (blood bank fees)

0771 Vaccine Administration

FL 44 HCPCS/Rates/Modifiers

Note: HCPCS codes are required for all revenue codes except 083X, 084X, 085X, and 088X

90999 Report URR for hemodialysis patients; modifier required

J3490 Unclassified drug – use only when no other code is available; eport specific drug in Remarks section of claim

G0491 Dialysis procedure at a Medicare certified ESRD facility (for Acute Kidney Injury without ESRD).

Note: When applicable, additional HCPCS/CPT codes should be included on the claim

FL 44 Modifiers Required for Reduction In ESA (Erythropoietin Stimulating Agent)

Note: Modifiers GS, ED, and EE **are not** required for DOS on/after 1/1/2020

Prescribing practitioners should continue to prescribe ESAs in accordance with ESA dosing guidelines and ESRD facilities should continue to report what they furnish.

ESRD facilities must continue to report all necessary information for the ESRD Quality Incentive Program. CMS has in place a monitoring program that studies the trends and behaviors of ESRD facilities under the ESRD PPS and the health outcomes of the beneficiaries who receives their care. CMS will continue to monitor the utilization of ESAs and any changes in the outlier policy to determine if additional MUEs are necessary.

GS Dosage of ESA has been reduced and maintained in response to hematocrit or hemoglobin level

Note: No longer required for DOS on/after 1/1/2020

ED Hematocrit level has exceeded 39.0% (or hemoglobin level has exceeded 13.0 g/dL) for three or more consecutive billing cycles immediately prior to and including the current billing cycle

Note: No longer required for DOS on/after 1/1/2020

EE Hematocrit level has not exceeded 39.0% (or hemoglobin level has not exceeded 13.0 g/dL) for three or more consecutive billing cycles immediately prior to and including the current billing cycle Hematocrit level exceeds 39 percent

Note: No longer required for DOS on/after 1/1/2020

Note: Maximum Number of Allowable Administrations per billing cycle (month) EPO: 13 times in 30 days and 14 times in 31 days. Aranesp: 5 times in 30/ 31days. Peginesatide: 1 time in 30/ 31days
FL 44 Modifiers Required for Adequacy of Hemodialysis **Note:** One of the G1 through G6 modifiers must be reported with HCCPS code 90999 on at least one hemodialysis revenue code line (revenue code 0820, 0821, 0825 or 0829)
G1 Most recent URR of less than 60%
G2 Most recent URR of 60% to 64.9%
G3 Most recent URR of 65% to 69.9%
G4 Most recent URR of 70% to 74.9%
G5 Most recent URR of 75% or greater
G6 ESRD patient for whom less than seven dialysis sessions have been provided in a month
FL 44 Modifiers
AX Furnished in conjunction with dialysis – TDAPA services (effective 1/1/2018) and TPNIES
AY Service not related to treatment of ESRD
CG Attestation that hemodialysis treatment in excess of monthly allowed does not meet medical necessity (effective 10/1/2017) **Note:** Used when billing of hemodialysis treatments for patients with ESRD in excess of the 13 (30 day month) or 14 (31 day month) monthly allowable treatments; applies to Revenue Codes 0821 and 0881; policy is applicable for all condition codes
ET Emergency services; used on outpatient hospital claim (non- ESRD claim) to attest that laboratory test(s) were ordered in conjunction with the emergency services (containing revenue code 045X) to emergency services often span two calendar days
KX Medical Policy requirements met for extra session
UJ Services provide at night (nocturnal) – typically longer, slower hemodialysis
EM Emergency Reserve Supply of EPO (for ESRD benefit only) – only for patient beginning self-administration of ESA at home
V8 Dialysis-access related iinfection present **(no longer required)**

V9 No dialysis-access related infection present **(no longer required)**
FL 44 Modifiers for Administration Route
JA Intravenous administration (ESA)
JB Subcutaneous administration (ESA)
JE Drug/biological administered via dialysate
FL 44 Modifiers for Vascular Access for Hemodialysis **Note:** Must report at least one modifier V5, V6, or V7 on latest hemodialysis LIDOS
V5 Vascular Catheter (alone or with any other vascular access) even if not being used for hemodialysis
V6 Arteriovenous Graft (or other Vascular Access not including a vascular catheter
V7 Arteriovenous Fistula Only (in use with two needles)
FL 44 Drug Amount Discarded Modifier (for single vial or package – not for multiple use vials)
JW Drug Amount Discarded/Not administered to any patient
FL 45 Service Date
Report the line item date of service for each dialysis session and each separately payable item or service
FL 46 Service Units
Note: Typically, number of units, reported in FL 46, should equal the number of times the service was performed according to current CPT/HCPCS code definition.
FL 67 ICD-10-CM Diagnosis Code
Hospital-based and independent renal facilities must complete this item and it should include a diagnosis of end stage renal disease for patients with ESRD. **Note:** ICD-10 code N186 is typically included as one of the diagnosis codes Acute kidney disease (AKI) claims must include an applicable ICD-10 diagnosis code as per the list available on the CMS website Acute Kidney Injury and ESRD Facilities
When applicable: Additional diagnosis codes as well as any comorbid ICD-10 codes
FL 80 Remarks

Available for use
FL 18-28 Claim Change Reason Codes (applicable for adjustments) – report in Condition Code Field – report only one on adjustment/cancel claim - choose single reason that best describes adjustment
D0 Change in service dates **D1** Change in charges **D2** Change in revenue/HCPCS code **D4** Change in diagnosis/procedure code **D7** Change to make Medicare secondary payer **D8** Change to make Medicare primary payer **D9** Other change (indicate reason in REMARKS field) **E0** Change in patient status Reference: NGS FISS/DDE Provider Online Guide, FISS Reason Codes
FL 64 Document Control Number
Required on adjustment request

Frequency of Dialysis Sessions by Dialysis Modality and Treatment Setting		
Dialysis Type	**In-facility**	**Home**
Hemodialysis (HD)	3 per week	Maximum of 3 per week regardless of frequency
Hemofiltration	3 per week	3 per week
Ultrafiltration	3 per week	Maximum of 3 per week regardless of frequency
CAPD/CCPD Dialysis	HD equivalent sessions	HD-equivalent sessions
Intermittent Peritoneal Dialysis (IPD)	3 per week	HD-equivalent sessions
ESRD facilities furnishing dialysis in-facility or in a patient's home are paid for a maximum of 13 treatments during a 30-day month or 14 treatments during a 31-day month unless there is medical justification for additional treatments		
Reference: CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 11, End Stage Renal Disease (ESRD), Section 50 – ESRD Prospective Payment System (PPS) Base Rate		

Non-ESRD Facility: Providing services to a Medicare beneficiary with ESRD ESRD PPS includes certain services that are subject to consolidated billing when provided by a non-ESRD facility
HCPCS code G0257 Unscheduled or emergency dialysis treatment for an ESRD patient in a hospital outpatient department that is not certified as an ESRD facility **Note:** Payment for unscheduled dialysis furnished to ESRD outpatients in a non-ESRD certified hospital outpatient department (TOB 13X or 85X only) is limited to a few specific circumstances discussed in the CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 4, Section 200.2, Hospital Dialysis Services For Patients With and Without End Stage Renal Disease (ESRD)

AY Modifier Service not related to treatment of ESRD
 	
Note: When a provider other than an ESRD facility provides renal dialysis services to an ESRD beneficiary for reasons not related to the treatment of ESRD, the submitted claim must include the AY modifier to allow for separate payment under Medicare. For example, if an ESRD beneficiary also has cancer and has a laboratory test done related to cancer treatment, the laboratory should submit the claim with an AY modifier in order to receive separate payment.
 	
Clarification
• The AY modifier is not required when laboratory services are billed in conjunction with an emergency room visit billed on a hospital outpatient claim
• Emergency services spanning two calendar days.
  ○ Hospital claim must include an emergency room service billed with revenue code 045x on a line item date that differs from the line item date of service for the related laboratory test(s)
  ▪ Include the modifier ET to attest that the laboratory test(s) were ordered in conjunction with the emergency services
 	
Additional information: CMS ESRD Consolidated Billing Website

Additional Information

Patient with Acute or Chronic Kidney Failure but not Eligible for Medicare

Outpatient dialysis services for a patient with acute kidney failure or chronic kidney failure but not eligible for Medicare under the ESRD provisions at the time services are rendered must be billed by the hospital and cannot be billed by a Medicare certified renal dialysis facility on bill type 72x. The ESRD PPS base rate is not paid.

Acute Kidney Injury

Acute kidney injury (AKI) claims are billed on the 072X type of bill with:

- Condition code 84
- Revenue code 082X, 083x, or 088x for the modality of dialysis furnished

- HCPCS code G0491 (Dialysis procedure at a Medicare certified ESRD facility for AKI without ESRD).
- AKI claims do not receive payment adjustments for comorbidities, TDAPA, TPNIES or outlier services
- The ESRD network reduction is not applicable to AKI claims

Additional information on AKI, including ICD-10 diagnosis codes: Acute Kidney Injury and ESRD Facilities

Incomplete Treatment

A dialysis treatment is started, when a patient is connected to the machine and a dialyzer and bloodlines are used. However, if the session is not completed for some unforeseen, but valid reason such as a medical emergency when the patient must be rushed to an emergency room, the facility is paid based on the full Prospective Payment System (PPS) base rate.

Note: This is a rare occurrence and must be fully documented in the medical record.

No Show

If a facility sets up in preparation for a dialysis treatment, but the treatment is never started because the patient never arrives, no payment is made. In this case, no service has been furnished to a Medicare beneficiary even though staff time and supplies may have been used. Furthermore, the facility may not bill the patient or the patient's private insurance for these services

Transitional Drug Add-on Payment

Under the ESRD PPS drug designation process, CMS will pay for the new drug or biological using a transitional drug add-on payment adjustment, if the new injectable or intravenous drug or biological is used to treat or manage a condition for which there is not an existing ESRD PPS functional category.

Drugs eligible for the transitional drug add-on payment (TDAPA) must billed with:

- Revenue code 0636
- Modifier AX must be appended to the applicable HCPCS code
- TDAPA claim lines are shown as covered line items but no payment will be included on the line item. The TDAPA is included in the prospective payment amount on the dialysis revenue code lines
- Payer Only Value code Q8: Captures the total allowable payment for the TDAPA.
    - The ESRD Pricer divides the Q8 amount by the total number of dialysis treatments and the per treatment amount is added to the PPS rate and included in each dialysis line payment.

Additional information on the TDAPA is available on the CMS website: ESRD PPS Transitional Drug Add-on Payment Adjustment

Transitional Add-on Payment Adjustment for New and Innovative Equipment and Supplies (TPNIES): ESRD PPS provides TPNIES for new and innovative renal dialysis equipment and supplies that qualify under the SSA Section 413.236. The TPNIES is paid for two calendar years, beginning on January 1 and ending on December 31. Note that such new and innovative equipment or supply is not considered an outlier service.

Beginning 1/1/2021, there are no equipment or supplies that qualify for the TPNIES. When available, NGS, your MAC, will provide pricing information for equipment and supplies that are paid under the ESRD PPS using the TPNIES.

Items eligible for the TPNIES must billed with:

- Revenue code 027X
- Modifier AX must be appended to the applicable HCPCS code
  - Until TPNIES items receive a HCPCS code report:
    - TPNIES supplies with HCPCS A4913 for miscellaneous dialysis supply not otherwise specified
    - TPNIES equipment with HCPCS code E1699 for miscellaneous dialysis equipment not otherwise specified.
- TPNIES claim lines are shown as covered line items but no payment will be included on the line item. The TPNIES is included in the prospective payment amount on the dialysis revenue code lines.
- When billing for a TPNIES eligible equipment or supply, the Remarks field on claim must include the following details to allow NGS, your MAC, to consider this information for pricing. Note that NGS may request more information
  - HCPCS code
  - Description of item
  - Billed amount to Medicare
  - Invoice amount and number of units on invoice
  - Wholesale amount per item
  - Discount/rebate amount per item (even if bulk discount)
- Payer Only Value code QG captures the total allowable price for the TPNIES
  - The ESRD Pricer calculates the 65 percent of the MAC, NGS, determined price and divides the amount by the total number of dialysis treatments and the per treatment amount is added to the PPS rate and included in each dialysis line payment.

Additional information on the TPNIES is available on the CMS website: ESRD PPS Transitional Add-on Payment Adjustment for New and Innovative Equipment and Supplies (TPNIES)

Related Content

CMS website:

- End Stage Renal Disease (ESRD) Prospective Payment System (PPS)
- ESRD PPS Outlier Services
- ESRD Consolidated Billing
- CMS Internet-Only Manual (IOM) Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 11, End Stage Renal Disease (ESRD)
- CMS IOM Publication 100-04, *Medical Claims Processing Manual*, Chapter 8, Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims
- ESRD PC Pricer

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