CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 13588	**Date: January 28, 2026**
	Change Request 14354

SUBJECT: Completion of Changes to Remove Reliance on the AX Modifier to Accurately Pay End Stage Renal Disease (ESRD) Claims

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to modify Original Medicare systems to no longer use the AX modifier in ESRD payment calculations and to instruct dialysis providers to no longer submit the modifier. It also revises billing instructions regarding hemodiafiltration and Acute Kidney Injury (AKI) claims.

EFFECTIVE DATE: July 1, 2026
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2026

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	8/20/End Stage Renal Disease Prospective Payment System (ESRD PPS) Per Treatment Payment Amount
R	8/40/Acute Kidney Injury (AKI) Claims
R	8/50.3/Required Information for In-Facility Claims Paid Under the End Stage Renal Disease Prospective Payment System ESRD PPS
R	8/50.6.2/Payment for Hemodialysis Sessions

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 13588	Date: January 28, 2026	Change Request: 14354

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I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to modify Original Medicare systems to no longer use the AX modifier in ESRD payment calculations and to instruct dialysis providers to no longer submit the modifier. It also revises billing instructions regarding hemodiafiltration and Acute Kidney Injury (AKI) claims.

II. GENERAL INFORMATION

A. Background: Effective January 1, 2011, CMS implemented the ESRD PPS based on the requirements of section 1881(b)(14) of the Social Security Act (the Act). The ESRD PPS provides a single per treatment payment to ESRD facilities that covers all the resources used in furnishing an outpatient dialysis treatment. The ESRD PPS base rate is adjusted to reflect patient and facility characteristics that contribute to higher per treatment costs.

In accordance with section 1834(r) of the Act, as added by section 808(b) of the Trade Preferences Extension Act of 2015, CMS pays ESRD facilities for furnishing renal dialysis services to Medicare beneficiaries with AKI. CR 9598 implemented the payment for AKI renal dialysis services and provides detailed information regarding payment policies.

The ESRD PPS includes consolidated billing 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.

There are several add-on payment adjustments under the ESRD PPS, which are included in the single per treatment payment provided under the ESRD PPS. These payment adjustments include a transitional drug add-on payment adjustment (TDAPA) for certain new renal dialysis drugs and biological products (§ 413.234(c)) and a transitional payment for new and innovative equipment and supplies (TPNIES) for certain new and innovative renal dialysis equipment and supplies (§ 413.236(d)). The TPNIES generally does not apply for capital related assets (CRA), but it does apply for CRAs that are home dialysis machines when used in the home of a single patient. The TDAPA was originally established for only certain new renal dialysis drugs and biological products not included in the ESRD PPS base rate effective January 1, 2016, and was expanded to certain drugs and biological products in existing ESRD PPS functional categories effective January 1, 2020. The first drugs paid the TDAPA were calcimimetics, beginning January 1, 2018. The TPNIES was originally established for certain new and innovative equipment and supplies that are not capital related assets effective January 1, 2020, and was extended to certain CRAs that are home dialysis machines effective January 1, 2021.

The AX modifier (item furnished in conjunction with dialysis services) has historically been required throughout the ESRD PPS when ESRD facilities furnish renal dialysis services which qualify for the TDAPA, TPNIES and CRA TPNIES to indicate that the drug, biological product, equipment, supply or

CRA should receive the applicable payment adjustment. For example, when TDAPA eligible drugs or biological products were supplied during the TDAPA period and billed with the AX modifier, the TDAPA would be applied to that claim. Likewise, when the Healthcare Common Procedure Coding System (HCPCS) for a CRA that is eligible to receive TPNIES payment for CRA, the TPNIES for CRA pricing instructions apply when a HCPCS code on the TPNIES CRA list is reported with the AX modifier and a revenue code indicating home dialysis equipment (823, 833, 843, 853, or 889). When the AX modifier was omitted from a claim with such an eligible service, ESRD facilities would not receive separate payment for the service with or without the AY modifier and the claims processed the line item as covered with no separate payment under the ESRD PPS. Beginning January 1, 2018, injectable, intravenous, and oral calcimimetics qualified for the TDAPA. ESRD facilities were required to report the AX modifier with the HCPCS for these drugs and biological products to receive payment for these drugs using the TDAPA. The TDAPA pricing instructions applied when a HCPCS code for an eligible drug or biological product was reported with the AX modifier and revenue code 0636. We noted that the AX modifier was only to be used for drugs or biological products that qualified for payment using the TDAPA and ESRD facilities were instructed not to use the AX modifier for any other drugs or biological products.

Beginning January 1, 2021, ESRD facilities were required to report the AX modifier with the HCPCS code for innovative equipment or supplies eligible to receive TPNIES payment. The TPNIES pricing instructions applied when a HCPCS code on the TPNIES list was reported with the AX modifier and revenue code 027X. Beginning January 1, 2022, the TPNIES for CRA pricing instructions applied when a HCPCS code on the TPNIES CRA list was reported with the AX modifier and one of the following revenue codes:

• 0823, Hemodialysis Home Equipment
• 0833, Peritoneal Home Equipment
• 0843, Continuous Ambulatory Peritoneal Dialysis (CAPD) Home Equipment
• 0853, Continuous Cycling Peritoneal Dialysis (CCPD) Home Equipment
• 0889, Other Miscellaneous Dialysis (to be used for ultrafiltration home equipment).

Beginning January 1, 2018, ESRD facilities were instructed not to report the AX modifier on any claims for renal dialysis services furnished for beneficiaries with AKI as AKI dialysis claims are not eligible for TDAPA, TPNIES or CRA TPNIES.

B. Policy: We are modifying the following requirements related to the AX modifier, effective July 1, 2026.

- New renal dialysis drugs and biological products eligible for the TDAPA should no longer be billed with the AX modifier to receive the TDAPA. The TDAPA pricing instructions will apply when a HCPCS code on the TDAPA list is reported with revenue code 0636.
- Innovative equipment and supplies eligible for the TPNIES should no longer be billed with the AX modifier to receive the TPNIES. The TPNIES pricing instructions will apply when a HCPCS code on the TPNIES list is reported with revenue code 027X.
- CRA eligible for the CRA TPNIES should no longer be billed with the AX modifier to receive the CRA TPNIES. The CRA TPNIES pricing instructions will apply when a HCPCS code on the CRA TPNIES list is reported with one of the following revenue codes:
  o 0823, Hemodialysis Home Equipment
  o 0833, Peritoneal Home Equipment
  o 0843, Continuous Ambulatory Peritoneal Dialysis (CAPD) Home Equipment
  o 0853, Continuous Cycling Peritoneal Dialysis (CCPD) Home Equipment
  o 0889, Other Miscellaneous Dialysis (to be used for ultrafiltration home equipment).
- ESRD facilities should not bill any renal dialysis service with the AX modifier, unless otherwise notified by CMS.
- These modifications to the AX modifier do not impact prior, remaining TDAPA, TPNIES, and CRA TPNIES billing guidance.

This change does not impact payments for renal dialysis services furnished to AKI beneficiaries, which should continue not to be reported with the AX modifier.

Effective July 1, 2026, ESRD facilities should use revenue code 0829 and HCPCS 90999 when billing for hemodiafiltration. Hemodiafiltration claims billed with revenue code 0829 shall be paid at the same rate as if they were hemodialysis claims. ESRD facilities should continue to bill for only one treatment per day and should not bill for hemodialysis and hemodiafiltration on the same date of service.

In addition, effective July 1, 2026, ESRD facilities should use both condition code 76 and condition code 84 when billing for back-up in-facility dialysis for beneficiaries with AKI.

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
14354.1	Contractors shall not apply service lines to the outlier amount in value code 79 on an ESRD claim, TOB 072X when: • Revenue code is 027x, 0636, 0823, 0833, 0843, 0853 or 0889; and • HCPCS codes are present on the PRMTDAPA Parm and the service date is within the effective dates on the Parm.					X				
14354.2	The contractor shall no longer return to the provider TOB 072x ESRD claims when the AX modifier is reported with a non-TDAPA, non-TPNIES or non-TPNIES CRA HCPCS code with covered charges greater than zero. • Note: this is current reason code 36225.					X				
14354.3	The contractor shall no longer return to the provider TOB 072x ESRD claims					X				

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	when a TDAPA, TPNIES or TPNIES CRA HCPCS code with modifier AX is reported with the wrong revenue code and with covered charges greater than zero. • Note: this is current reason code 36227.									
14354.4	The contractor shall no longer return to the provider TOB 072x ESRD claims when modifier AX is reported on an AKI claim. • Note: Current reason codes 36228 and 36229. Services previously requiring the AX modifier will be processed according to BR 14354.5.					X				
14354.5	The contractor shall ensure line items are not paid separately on TOB 072x ESRD claims when TDAPA, TPNIES or TPNIES CRA HCPCS codes are reported on AKI claims when: • HCPCS codes are present on the PRMTDAPA Parm and the service date is within the effective dates on the Parm, and • Condition code 84 is present on the claim, and • HCPCS code G0491 is present. • Note: Diagnosis codes will not be validated as part of this edit. Correct					X				

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	diagnosis coding for AKI claims is enforced by reason code 31425.									
14354.5.1	Contractors shall not include service lines in the value code Q8, QG or QH amounts on an ESRD claim, TOB 072X when: • Revenue code is 027x, 0636, 0823, 0833, 0843, 0853 or 0889; and • HCPCS code is present on the PRMTDAPA Parm and the service date is within the effective dates on the Parm, and • Condition code 84 is present on the claim.					X				
14354.6	The contractor shall no longer return to the provider TOB 072x ESRD claims when a TPNIES or TPNIES CRA HCPCS code with modifier AX is reported with units greater than 1. • Note: this is current reason code 36237.					X				
14354.7	The contractor shall return to the provider TOB 072x ESRD claims when: • HCPCS codes are present on the PRMTDAPA Parm with a type indicator					X				

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	of TPNIES or TPNIES CRA and the service date is within the effective dates on the Parm, and • Units are greater than 1.									
14354.8	The contractor shall no longer suspend for manual pricing TOB 072x ESRD claims when a TPNIES CRA HCPCS code with modifier AX is reported, covered charges are present and the rate field for the code is blank. • Note: this end dates a condition in current reason code 32284.					X				
14354.9	The contractor shall suspend for manual pricing TOB 072x ESRD claims when • a HCPCS code is present on the PRMTDAPA Parm with a type indicator of TPNIES or TPNIES CRA and the service date is within the effective dates on the Parm, and • covered charges are present on the line, and • the rate field for the code is blank. • Note: This requirement references the rate field on Claim Page 03 (MAP1033).					X				

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
14354.10	The contractor shall allow AKI claims with condition code 84 to also report condition code 76, for back-up in facility dialysis treatments. • Note: this revises current reason code 36104.					X				
14354.11	The contractor shall pay hemodiafiltration services at the hemodialysis rate on ESRD claims with TOB 72x using revenue code 0829 and HCPCS 90999.					X				ESRD Pricer
14354.11.1	The contractor shall send covered line items with revenue code 0829 and HCPCS 90999 to the ESRD Pricer, including the line item date of service.					X				
14354.11.2	The contractor shall include covered line items with revenue code 0829 and HCPCS 90999 in the total number of dialysis sessions sent to the ESRD Pricer for outlier calculation.					X				
14354.11.3	The contractor shall calculate payment for line items with revenue code 0829 and HCPCS 90999 identically to line items with revenue code 0821.									ESRD Pricer
14354.12	The contractor shall return to the provider TOB 072x ESRD claims reporting more than one hemodialysis session on the same date of service, including any combination of revenue codes 0821 and 0829 when					X				

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	reported with covered charges. Examples: RTP claims with • Two 0821 lines on the same date of service • Two 0829 lines on the same date of service • One 0821 line and one 0829 line on the same date of service • One 0829 line with units greater than 1. Note: This modifies current reason code 36175, which prevents multiple hemodialysis sessions on the same day for revenue code 0821 only.									

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors: A/B MAC Part A, A/B MAC Part A

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: All other recommendations and supporting information: N/A

VI. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Claims Processing Manual

Chapter 8 - Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims

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(Rev.13588; Issued: 01-28-26)

20 - End Stage Renal Disease Prospective Payment System (ESRD PPS) Per Treatment Payment Amount

(Rev.13588; Issued:01-28-26; Effective: 07-01-26; Implementation:07-06-26)

A case mix methodology adjusts the Prospective Payment System (PPS) base rate based on a limited number of patient characteristics. Variables for which adjustments will be applied to the PPS base rate include age, body surface area (BSA), and low body mass index (BMI). These variables are determined in the ESRD PRICER to calculate the End Stage Renal Disease Prospective Payment System (ESRD PPS per treatment payment amount (including all other adjustments).

The following table contains claim data required to calculate the ESRD PPS per treatment payment amount.

Form CMS-1450	**ASC X12 837 institutional claim**
Through Date	2300 | DTP segment | 434 qualifier
Date of Birth	2010BA | DMG02
Condition Codes (73, 74, 87)	2300 | HI segment | BG qualifier
Value Codes (A8 and A9) / Amounts	2300 | HI segment | BE qualifier
Revenue Code (0821, 0831, 0841, 0851, 0880, or 0881)	2400 | SV201

For claims with dates of service on or after January 1, 2011, Medicare systems must pass the line item date of service dialysis revenue code lines when the onset of dialysis adjustment is applicable to one or more of the dialysis sessions reported on the claim.

Form CMS-1450	**ASC X12 837 institutional claim**
Line Item Date of Service for Revenue Code (0821, 0831, 0841, 0851	2400 | DTP Segment | D8 qualifier

In addition to the above claim data, the following payer only codes are required on claims with dates of service on or after January 1, 2011 to calculate the ESRD PPS per treatment payment amount:

Form CMS-1450	**Payer Only Format**
Payer Only Condition Codes (MA, MB, MC, MD, ME, MF) (Identifies comorbid conditions for adjustments)	X(2)
Payer Only Value Code (79) (Identifies dollar amount for services applicable for the calculation for determining outlier)	• X(2) V(9)
Payer Only Value Code (Q8) (Identifies dollar amount for services applicable for the calculation of the transitional drug add-on payment)	• X(2) V(9)

Form CMS-1450	Payer Only Format
Payer Only Value Code (QG) (Identifies dollar amount for services applicable for the calculation of the transitional payment for new innovative equipment and supplies)	• X(2) V(9)
Payer Only Value Code (QH) (Identifies dollar amount for services applicable for the calculation of the transitional payment for capital related assets for new innovative equipment	• X(2) V(9)

Note: The payer only codes above are assigned by the Medicare standard systems and are not submitted on the claim by the provider.

The following provider data must also be passed to the ESRD PRICER to make provider-specific calculations that determine the ESRD PPS per treatment payment amount:

Field	Format
Actual Geographic Location MSA	X(4)
Actual Geographic Location CBSA	X(5)
Special Wage Index	9(2)V9(4)
Supplemental Wage Index	9(2)V9(4)
Provider Type	X(2)
Special Payment Indicator	X(1)

In addition to the above provider data, the following is required to calculate the final ESRD PPS rate effective January 1, 2011:

Field	Format
Blended Payment Indicator	X(1)
Low-Volume Indicator	X (1)

Effective January 1, 2012 the following is required to calculate the Quality Incentive Program adjustment for ESRD facilities:

Field	Format
Quality Indicator Field	X(1)

Based on the claim and provider data shown above, the ESRD PRICER makes adjustments to the PPS base rate to determine the ESRD PPS per treatment payment amount. The following factors are used to adjust and make calculations to the ESRD PPS per treatment payment amount.

- Provider Type

- Drug add-on
- Budget Neutrality Factor
- Patient Age
- Patient Height
- Patient Weight
- Patient BSA
- Patient BMI
- BSA factor
- BMI factor
- Condition Code 73 adjustment (if applicable)
- Condition Code 74 adjustment (if applicable)
- Condition Code 84 for AKI patients (if applicable)
- Condition Code 87 adjustment (if applicable)

In addition to the above adjustments, the following adjustments may be applicable to the ESRD PPS base rate for **adult** patient claims with dates of service on or after January 1, 2011:

- Onset of Dialysis
- Patient Comorbidities
- Low-Volume ESRD Facility

Onset of Dialysis:

Providers will receive an adjustment to the ESRD PPS base rate for patients within the initial 120 calendar days from when an ESRD beneficiary began their maintenance dialysis. The provider does not report anything on the claim for this adjustment. The adjustment is determined by the start date of dialysis in the Common Working File as reported on the patient's 2728 form. When the onset of dialysis adjustment is provided, the claim is not entitled to a comorbidity adjustment or a training add-on adjustment.

Patient Comorbidities:

The ESRD PPS will provide adjustments for each category of chronic and acute comorbidity conditions, 3 categories of chronic conditions and 3 categories of acute conditions. **In the event that more than one of the comorbidity categories is present on the claim, the claim will be adjusted for the highest paying comorbidity category.**

Chronic Comorbidities

When chronic comorbidity codes are reported on the claim an 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 Comorbidities

Acute comorbidity category adjustments will be 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. Acute comorbidity conditions reported for more than four consecutive months will not receive additional payment.

In the event that the comorbidity condition was resolved and later reoccurred, the provider may submit a condition code to indicate the diagnosis is a reoccurrence. The adjustment will be applicable for an additional four months.

For a list of specific acute and chronic comorbid conditions eligible for adjustment, refer to the following website:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Patient-Level-Adjustments

This list may be updated as often as quarterly in January, April, July and October of each year.

Low-Volume ESRD Facilities:

ESRD facilities will receive an adjustment to their ESRD PPS base rate when the facility furnished less than 4,000 treatments in each of the three cost report years preceding the payment year and has not open, closed, or received a new provider number due to a change in ownership during the 3 years preceding the payment year. The ESRD facility must notify their A/B MAC (A) if they believe they are eligible for the low-volume adjustment. The A/B MAC (A) must validate the eligibility and update the provider specific file according to the ESRD facility's low-volume payment tier. Pediatric patient claims are not eligible for the low-volume adjustment.

A/B MACs (A) are instructed to validate the facility's eligibility for the low volume adjustment. If an A/B MAC (A) determines that an ESRD facility has received the low volume adjustment in error, the A/B MAC (A) is required to adjust all of the ESRD facility's affected claims to remove the adjustment within 6 months of finding the error.

In addition to the above adjustments, the following adjustments may be applicable to the ESRD PPS base rate for **adult and pediatric** patient claims with dates of service on or after January 1, 2011:

Training Adjustment: The ESRD PPS provides a training add-on of $33.44 adjusted by the ESRD PPS wage index that accounts for an hour of nursing time for training treatments. The add-on applies to both PD and HD training treatments**.**

ESRD PPS Outlier Payments:

The ESRD Prospective Payment System (PPS) includes a payment adjustment for high cost outliers when there are unusual variations in the type or amount of medically necessary care.

Outlier consideration is provided for the following:

- ESRD-related drugs and biologicals that were or would have been prior to January 1, 2011, either included under the case-mix adjusted composite payment system or separately billable under Medicare Part B;
- ESRD-related laboratory tests that were or would have been, prior to January 1, 2011 separately billable under Part B;
- Medical/surgical supplies, including syringes, used to administer ESRD-related drugs that were or would have been prior to January 1, 2011, separately billable under Medicare Part B; and
- Renal dialysis service drugs that were or would have been, prior to January 1, 2011 covered under Medicare Part D.
- For new injectable renal dialysis drugs and biologicals that are eligible outlier services, ESRD facilities should report J3591 with the National Drug Code (NDC) in the 11-digit format 5-4-2. The MAC will set the payment rate based on pricing methodologies under 1847A of the Act using the guidance in the Medicare Claims Processing Manual, Chapter 17 - Drugs and Biologicals, Section 20.1.3 - Exceptions to Average Sales Price (ASP) Payment Methodology.

Statute requires the delay of the implementation of the oral-only renal dialysis service policy until January 1, 2025. Services not included in the PPS that remain separately payable are not considered outlier services.

When the ESRD PRICER returns an outlier payment, the standard systems shall display the total applicable outlier payment on the claim with value code 17.

Information related to the outlier services eligible for adjustment can be found at the following website:

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Outlier_Services.html

This list may be updated as often as quarterly in January, April, July and October of each year.

For claims submitted with dates of service on or after January 1, 2012, all drugs reported on the ESRD claim under revenue codes 0634, 0635 and 0636 with a rate available on the ASP file will be considered in the Medicare allowed payment (MAP) amount for outlier consideration with the exception of any drugs reported with the AY modifier and drugs included in the original composite rate payment system.

Transitional Drug Add-On Payment Adjustment (TDAPA)

Effective January 1, 2016 under the ESRD PPS drug designation process, CMS provides payment using a Transitional Drug Add-on Payment Adjustment (TDAPA) for new renal dialysis new injectable or intravenous drugs and biologicals that qualify under 42 CFR 413.234(c)(1).
CMS will pay for the 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. CMS bases the TDAPA on payment methodologies under section 1847A of the Social Security Act which are discussed in Pub. 100-04, Chapter 17, Section 20. The MAC will set the payment rate based on pricing methodologies under 1847A of the Act using the guidance in the Medicare Claims Processing Manual, Chapter 17 - Drugs and Biologicals, Section 20.1.3 - Exceptions to Average Sales Price (ASP) Payment Methodology. This payment is applicable for a period of 2 years.
While the TDAPA applies to a new injectable or intravenous drug or biological, the drug or biological is not considered an outlier service, is not separately payable with the AY modifier and does not apply to acute kidney injury claims (AKI).
Drugs eligible for the TDAPA must be billed with revenue code 0636 and*, for dates of service before July 1, 2026,* modifier AX must be appended to the HCPCS.

- The 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.
- Q8 payer only value code 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 PPS rate and included in each dialysis line payment.

Additional information on the TDAPA is available on the CMS website located at:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/ESRD-Transitional-Drug

Transitional Add-on Payment Adjustment for New and Innovative Equipment and Supplies (TPNIES)

Beginning January 1, 2020, the ESRD PPS provides the Transitional Add-on Payment Adjustment for New and Innovative Equipment and Supplies (TPNIES) for new and innovative renal dialysis equipment and supplies that qualify under § 413.236.

The TPNIES payment is based on 65 percent of the Medicare Administrative Contractor (MAC) determined price. The MACs, on behalf of CMS, establish prices for new and innovative renal dialysis equipment and supplies that meet the TPNIES eligibility criteria using verifiable information from the following sources of information, if available:

- the invoice amount, facility charges for the item, discounts, allowances, and rebates;
- the price established for the item by other MACs and the sources of information used to establish that price;
- payment amounts determined by other payers and the information used to establish those payment amounts;
- charges and payment amounts required for other equipment and supplies that may be comparable or otherwise relevant.
-

The TPNIES is paid for 2 calendar years, beginning on January 1 and ending on December 31. While the TPNIES applies to a new and innovative equipment or supply, the equipment or supply is not considered an outlier service.

Items eligible for the TPNIES must be billed with revenue code 027X and*, for dates of service before July 1, 2026*, modifier AX must be appended to the HCPCS. Until TPNIES items receive a HCPCS the TPNIES supplies are reported with HCPCS A4913 for miscellaneous dialysis supply not otherwise specified and for TPNIES equipment HCPCS E1699 is reported for miscellaneous dialysis equipment not otherwise specified.

- The 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.
- QG payer only value code captures the total allowable price for the TPNIES. The ESRD pricer calculates the 65 percent of the MAC determined price and divides the amount by the total number of dialysis treatments and the per treatment amount is added to PPS rate and included in each dialysis line payment.

Transitional Add-on Payment Adjustment for New and Innovative Equipment and Supplies (TPNIES) for Capital Related Assets (CRA)

Beginning January 1, 2021, the TPNIES policy was expanded to include CRA that are home dialysis machines when used in the home for a single patient. For CRA for TPNIES only, CMS includes an offset adjustment to offset the costs already paid for dialysis machines in the ESRD PPS bundle. Effective January 1, 2022, CMS annually updates the offset adjustment amount by the ESRD bundled market basket percentage increase factor minus the productivity adjustment factor. The payment for CRA for TPNIES is based on 65 percent of the MAC determined price (see below), reduced by the offset adjustment amount described in the prior sentences.

The MACs, on behalf of CMS, establish prices for new and innovative renal dialysis equipment and supplies, including certain CRA that are home dialysis machines, that meet the TPNIES eligibility criteria using verifiable information from the following sources of information, if available:

- the invoice amount, facility charges for the item, discounts, allowances, and rebates;
- the price established for the item by other MACs and the sources of information used to establish that price;
- payment amounts determined by other payers and the information used to establish those payment amounts;
- charges and payment amounts required for other equipment and supplies that may be comparable or otherwise relevant.

The TPNIES for CRA is paid for 2 calendar years, beginning on January 1 of the approval year and ending on December 31 the following year. Following payment of the TPNIES for CRA, the ESRD PPS base rate will not be modified and the new CRA that is a home dialysis machine will not be an eligible outlier service as provided in § 413.237.

Beginning January 1, 2021 *and continuing through dates of service before July 1, 2026*, ESRD facilities report the AX modifier (item furnished in conjunction with dialysis services) with the HCPCS code for the

CRA that is eligible to receive TPNIES payment for CRA. The TPNIES for CRA pricing instructions apply when a HCPCS code on the TPNIES CRA list is reported and one of the following revenue codes:

•0823, Hemodialysis Home Equipment
• 0833, Peritoneal Home Equipment
• 0843, Continuous Ambulatory Peritoneal Dialysis (CAPD) Home Equipment
• 0853, Continuous Cycling Peritoneal Dialysis (CCPD) Home Equipment
• 0889, Other Miscellaneous Dialysis (to be used for ultrafiltration home equipment).

For CRAs that are home dialysis machines used in the home for a single patient, the MACs shall divide the annual allowance by the expected number of treatments to calculate the annual allowance and the per treatment amount. The expected number of treatments is always 156 per year. MACs shall assign an amount to value code QH (Total TPNIES CRA amount) which totals the CRA for TPNIES per treatment amount multiplied by the number of treatments on that claim.

The number of dialysis treatments for the month used in the CRA for TPNIES calculation, is limited to the 13 to 14 allowable monthly treatments that are deemed medically necessary. Dialysis treatments exceeding 13 to 14 per month (3 treatments per week) that are determined reasonable and necessary by the Medicare contractors are payable; however, treatments that exceed 13 to 14 per month shall not be considered for separate pricing for CRA for TPNIES. ESRD facilities should not bill separate line items for CRA for TPNIES in excess of 13 to 14 treatments per month. Regardless of the number of treatments given per month, the adjusted CRA for TPNIES per treatment amount will equal the adjusted CRA for TPNIES per treatment amount that is calculated for 13 treatments per month. MACs shall not allow CRA for TPNIES in excess of 156 treatments per calendar year.

Pricer puts a payment at the dialysis line so that it is a per treatment payment. Therefore, Pricer calculates the adjusted per treatment amount that is added to each dialysis line by: 1) dividing QH by the total number of administered dialysis treatments, 2) subtracting the applicable offset amount, and 3) multiplying by 65 percent.

CRA for TPNIES is not applicable to the per treatment payment amount that is paid to ESRD facilities for furnishing dialysis to individuals with Acute Kidney Injury (AKI).

40 - Acute Kidney Injury (AKI) Claims

(Rev.13588; Issued:01-28-26; Effective: 07-01-26; Implementation:07-06-26)

Effective January 1, 2017, ESRD facilities, both hospital based and freestanding are able to furnish dialysis to AKI patients and receive payment under the ESRD PPS.

Medicare will pay ESRD facilities for the dialysis treatment using the ESRD PPS base rate adjusted by the applicable ESRD PPS wage index. In addition to the dialysis treatment, the ESRD PPS base rate pays ESRD facilities for other items and services considered to be renal dialysis services as defined in 42 CFR §413.171. No separate payment is made for those services considered to be renal dialysis services as payment is included in the ESRD PPS base rate.

Other items and services that are furnished to beneficiaries with AKI that are not considered to be renal dialysis services but are related to their dialysis as a result of their AKI, would be separately payable, this includes drugs, biologicals, laboratory services, and supplies that ESRD facilities are certified to furnish and that would otherwise be furnished to a beneficiary with AKI in a hospital outpatient setting.

AKI claims are billed on the 072X type of bill with condition code 84. ESRD facilities are required to include revenue code 082X, 083x, or 088x for the modality of dialysis furnished with the Current Procedural Terminology (CPT) code G0491 (Dialysis procedure at a Medicare certified ESRD facility for Acute Kidney Injury without ESRD).

AKI claims do not receive payment adjustments for comorbidities, TDAPA, TPNIES or outlier. When applicable, AKI claims receive the home dialysis training add-on payment adjustment (see section 50.8). The ESRD network reduction is not applicable to AKI claims.

Reporting additional condition codes:

- *Effective January 1, 2025, AKI claims for dialysis in the home setting must also include condition code 74.*
- *Effective January 1, 2025, AKI claims for training or re-training for AKI home and self-dialysis must also include either condition code 73 or 87 as appropriate.*
- *Effective July 1, 2025, AKI claims for home dialysis patients who require an in-center back-up dialysis treatment may also include condition code 76.*

More information on dialysis provided for AKI patients including the required diagnosis codes for billing AKI is available on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/AKI-and-ESRD-Facilities.

50.3 - Required Information for In-Facility Claims Paid Under the End Stage Renal Disease Prospective Payment System ESRD PPS

(Rev.13588; Issued:01-28-26; Effective: 07-01-26; Implementation:07-06-26)

The term Medicare beneficiary identifier (MBI) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

The electronic form required for billing ESRD claims is the ASC X12 837 institutional claim transaction. The paper form, where permissible, is Form CMS-1450.

The coding and related descriptions for the following items are identical for the ASC X12 837 institutional claim format and Form CMS-1450. See the related X12 implementation guide or Chapter 25, respectively, for where the information is reported.

Type of Bill

Acceptable codes for Medicare are:

721 - Admit Through Discharge Claim - This code is used for a bill encompassing an entire course of outpatient treatment for which the provider expects payment from the payer.

722 - Interim - First Claim - This code is used for the first of an expected series of payment bills for the same course of treatment.

723 - Interim - Continuing Claim - This code is used when a payment bill for the same course of treatment is submitted and further bills are expected to be submitted later.

724 - Interim - Last Claim - This code is used for a payment bill which is the last of a series for this course of treatment. The "Through" date of this bill (FL 6) is the discharge date for this course of treatment.

727 - Replacement of Prior Claim - This code is used when the provider wants to correct (other than late charges) a previously submitted bill. The previously submitted bill needs to be resubmitted in its entirety, changing only the items that need correction. This is the code used for the corrected or "new" bill.

728 - Void/Cancel of a Prior Claim - This code indicates this bill is a cancel-only adjustment of an incorrect bill previously submitted. Cancel-only adjustments should be used only in cases of incorrect provider identification numbers, incorrect Medicare beneficiary identifier, duplicate payments and some OIG recoveries. For incorrect provider numbers or Medicare beneficiary identifier, a corrected bill is also submitted using a code 721.

Statement Covers Period (From-Through) - Hospital-based and independent renal dialysis facilities:

The beginning and ending service dates of the period included on this bill. Note: ESRD services are subject to the monthly billing requirements for repetitive services.

Condition Codes

Hospital-based and independent renal facilities complete these items. Note that one of the codes 71-76 is applicable for every bill. Special Program Indicator codes A0-A9 are not required.

Condition Code Structure (only codes affecting Medicare payment/processing are shown).

02 - Condition is Employment Related - Providers enter this code if the patient alleges that the medical condition causing this episode of care is due to environment/events resulting from employment.

04 - Information Only Bill - Providers enter this code to indicate the patient is a member of a Medicare Advantage plan.

59 – Non-Primary ESRD Facility – Providers enter this code to indicate that ESRD beneficiary received non-scheduled or emergency dialysis services at a facility other than his/her primary ESRD dialysis facility.

71 - Full Care in Unit - Providers enter this code to indicate the billing is for a patient who received staff-assisted dialysis services in a hospital or renal dialysis facility.

72 - Self-Care in Unit - Providers enter this code to indicate the billing is for a patient who managed his own dialysis in a hospital or renal dialysis facility.

73 - Self-Care in Training - Providers enter this code to indicate the billing is for special dialysis services where a patient and his/her helper (if necessary) were learning to perform dialysis.

74- Home-Providers enter this code to indicate the billing is for a patient who received dialysis services at home.

76 - Back-up In-facility Dialysis - Providers enter this code to indicate the billing is for a home dialysis patient who received back-up dialysis in a facility.

80- Home Dialysis-Nursing Facility – Home dialysis furnished in a SNF or Nursing Facility (report with condition code 74).

84 – Acute Kidney Injury- Provider enters this code to indicate the claim is for an AKI patient.

87 – Retraining – Provider enters this code to indicate the billing is for retraining of the patient and his/her helper (if necessary) to perform self-care dialysis.

H3 – Reoccurrence of GI Bleed comorbid category

H4 – Reoccurrence of Pneumonia comorbid category

H5 – Reoccurrence of Pericarditis comorbid Category

Occurrence Codes and Dates

Codes(s) and associated date(s) defining specific events(s) relating to this billing period are shown. Event codes are two alpha-numeric digits, and dates are shown as six numeric digits (MM-DD-YY). When occurrence codes 01-04 and 24 are entered, make sure the entry includes the appropriate value code, if there is another payer involved.

Occurrence and occurrence span codes are mutually exclusive. Occurrence codes have values from 01 through 69 and A0 through L9. Occurrence span codes have values from 70 through 99 and M0 through Z9.

24 - Date Insurance Denied - Code indicates the date of receipt of a denial of coverage by a higher priority payer.

33 - First Day of Medicare Coordination Period for ESRD Beneficiaries Covered by an EGHP - Code indicates the first day of the Medicare coordination period during which Medicare benefits are payable under an EGHP. This is required only for ESRD beneficiaries.

51 – Date of last Kt/V reading. For in-center hemodialysis patients, this is the date of the last reading taken during the billing period. For peritoneal dialysis patients and home hemodialysis patients, this date may be before the current billing period but should be within 4 months of the claim date of service.

Occurrence Span Code and Dates

Code(s) and associated beginning and ending dates(s) defining a specific event relating to this billing period are shown. Event codes are two alpha-numeric digits and dates are shown numerically as MM-DD-YY.

74 - Noncovered Level of Care - This code is used for repetitive Part B services to show a period of inpatient hospital care or of outpatient surgery during the billing period. Use of this code will not be necessary for ESRD claims with dates of service on or after April 1, 2007 due to the requirement of ESRD line item billing.

Document Control Number (DCN)

Required for all provider types on adjustment requests. (Bill Type/FL=XX7). All providers requesting an adjustment to a previous processed claim insert the DCN of the claims to be adjusted.

Value Codes and Amounts

Code(s) and related dollar amount(s) identify monetary data that are necessary for the processing of this claim. The codes are two alphanumeric digits and each value allows up to nine numeric digits (0000000.00). Negative amounts are not allowed. Whole numbers or non-dollar amounts are right justified to the left of the dollars and cents delimiter. Some values are reported as cents, so refer to specific codes for instructions. If more than one value code is shown for a billing period, show the codes in ascending alphanumeric sequence.

Value Code Structure (Only codes used to bill Medicare are shown.):

06 - Medicare Blood Deductible - Code indicates the amount the patient paid for un-replaced deductible blood.

13 - ESRD Beneficiary in the 30- Month Coordination Period with an EGHP - Code indicates that the amount shown is that portion of a higher priority EGHP payment on behalf of an ESRD beneficiary that applies to covered Medicare charges on this bill. If the provider enters six zeros (0000.00) in the amount

field, it is claiming a conditional payment because the EGHP has denied coverage or there has been a substantial delay in its payment. Where the provider received no payment or a reduced payment because of failure to file a proper claim, this is the amount that would have been payable had it filed a proper claim.

17 – Not submitted by the provider. The Medicare shared system will display this payer only code on the claim when an outlier payment is being made. The value is the total claim outlier payment.

19 – Not submitted by the provider. The Medicare shared system will display this payer only code on the claim for low volume providers to identify the amount of the low volume adjustment being included in the provider's reimbursement.

37 - Pints of Blood Furnished - Code indicates the total number of pints of blood or units of packed red cells furnished, whether or not replaced. Blood is reported only in terms of complete pints rounded upwards, e.g., 1 1/4 pints is shown as 2 pints. This entry serves a basis for counting pints towards the blood deductible. Hospital-based and independent renal facilities must complete this item.

38 - Blood Deductible Pints - Code indicates the number of un-replaced deductible pints of blood supplied. If all deductible pints furnished have been replaced, no entry is made. Hospital-based and independent renal facilities must complete this item.

39 - Pints of Blood Replaced - Code indicates the total number of pints of blood donated on the patient's behalf. Where one pint is donated, one pint is replaced. If arrangements have been made for replacement, pints are shown as replaced. Where the provider charges only for the blood processing and administration, i.e., it does not charge a "replacement deposit fee" for un-replaced pints, the blood is considered replaced for purposes of this item. In such cases, all blood charges are shown under the 039x revenue code series, Blood Administration. Hospital-based and independent renal facilities must complete this item.

44 - Amount Provider Agreed To Accept From Primary Payer When This Amount is Less Than Charges But Higher than Payment Received - Code indicates the amount shown is the amount the provider was obligated or required to accept from a primary payer as payment in full when that amount is less than the charges but higher than amount actually received. A Medicare secondary payment is due.

47 - Any Liability Insurance - Code indicates amount shown is that portion from a higher priority liability insurance made on behalf of a Medicare beneficiary that the provider is applying to Medicare covered services on this bill. If six zeros (0000.00) are entered in the amount field, the provider is claiming conditional payment because there has been substantial delay in the other payer's payment.

48 - Hemoglobin Reading - Code indicates the most recent hemoglobin reading taken before the start of this billing period. This is usually reported in three positions with a decimal. Use the right of the delimiter for the third digit. The blood sample for the hemoglobin reading must be obtained before the dialysis treatment. If a hemoglobin value is not available facilities must report the value 99.99.

49 - Hematocrit Reading - Code indicates the most recent hematocrit reading taken before the start of this billing period. This is usually reported in two positions (a percentage) to the left of the dollar/cents delimiter. If the reading is provided with a decimal, use the position to the right of the delimiter for the third digit. The blood sample for the hemoglobin reading must be obtained before the dialysis treatment. If a hematocrit value is not available facilities must report the value 99.99

71 - Funding of ESRD Networks - Code indicates the amount of Medicare payment reduction to help fund the ESRD networks. This amount is calculated by the A/B MAC (A) and forwarded to CWF. (See §120 for discussion of ESRD networks).

79 – Not submitted by the provider. The Medicare shared system will display this payer only code on the claim. The value represents the dollar amount for Medicare allowed payments applicable for the calculation in determining an outlier payment.

A8 – Weight of Patient – Code indicates the weight of the patient in kilograms. The weight of the patient should be measured after the last dialysis session of the month.

A9 – Height of Patient – Code indicates the height of the patient in centimeters. The height of the patient should be measured during the last dialysis session of the month. The measurement is required no less frequently than once per year but must be reported on every claim. This height is as the patient presents.

D5 – Result of last Kt/V reading. For in-center hemodialysis patients this is the last reading taken during the billing period. For peritoneal dialysis patients and home hemodialysis this may be before the current billing period but should be within 4 months of the claim date of service.

D6 – The number of minutes (rounded to the nearest whole minute) between the beginning of dialysis treatment time (i.e. , when the start button on the blood pump is pushed) and the end of dialysis treatment time (i.e., when the stop button on the blood pump is pushed). ESRD facilities are not required to reduce the total count of minutes to account for disruptions due to machine failures, bathroom breaks, or other stoppage, but the number of minutes reported should not include time outside the start and end of the dialysis session (for example, time when the patient is in-center waiting to be seated in a chair). The time on dialysis machine duration begins when the actual dialysis treatment starts and ends when the actual dialysis treatment is complete. The units reported must exceed 1.

Q8 – Not submitted by the provider. The Medicare shared system will display this payer only code on the claim. The value represents the dollar amount for the services applicable to the calculation of the transitional drug add-on adjustment (TDAPA).

QG – Not submitted by the provider. The Medicare shared system will display this payer only code on the claim. The value represents the dollar amount for the services applicable to the calculation of the new innovative equipment and supplies add-on adjustment (TPNIES).

QH – Not submitted by the provider. The Medicare shared system will display this payer only code on the claim. The value represents the dollar amount for the services applicable to the calculation of the new innovative equipment add-on for capital related assets.

Revenue Codes

The revenue code for the appropriate treatment modality is billed (e.g., 0821 for hemodialysis). Effective January 1, 2015, ESRD facilities are required to report on the claim the drugs identified on the consolidated billing list provided at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Consolidated_Billing.html

082X - Hemodialysis - Outpatient or Home Dialysis - A waste removal process performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed directly from the blood. Detailed revenue coding is required. Therefore, services may not be summed at the zero level.

0 - General Classification	HEMO/OP OR HOME
1 – Hemodialysis/Composite or other rate	HEMO/COMPOSITE
2 - Home Supplies	HEMO/HOME/SUPPL
3 - Home Equipment	HEMO/HOME/EQUIP
4 - Maintenance 100%	HEMO/HOME/100%
5 - Support Services	HEMO/HOME/SUPSERV
9 - Other Hemodialysis Outpatient	HEMO/HOME/OTHER

Report hemodiafiltration sessions using revenue code 0829.

083X - Peritoneal Dialysis - Outpatient or Home - A waste removal process performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed indirectly by instilling a special solution into the abdomen using the peritoneal membrane as a filter.

0 - General Classification	PERITONEAL/OP OR HOME
1 - Peritoneal/Composite or other rate	PERTNL/COMPOSITE
2 - Home Supplies	PERTNL/HOME/SUPPL
3 - Home Equipment	PERTNL/HOME/EQUIP
4 - Maintenance 100%	PERTNL/HOME/100%
5 - Support Services	PERTNL/HOME/SUPSERV
9 -Other Peritoneal Dialysis	PERTNL/HOME/OTHER

084X - Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient - A continuous dialysis process performed in an outpatient or home setting, which uses the patient's peritoneal membrane as a dialyzer.

0 - General Classification	CAPD/OP OR HOME
1 - CAPD/Composite or other rate	CAPD/COMPOSITE
2 - Home Supplies	CAPD/HOME/SUPPL
3 - Home Equipment	CAPD/HOME/EQUIP
4 - Maintenance 100%	CAPD/HOME/100%
5 - Support Services	CAPD/HOME/SUPSERV
9 -Other CAPD Dialysis	CAPD/HOME/OTHER

085X - Continuous Cycling Peritoneal Dialysis (CCPD) - Outpatient. - A continuous dialysis process performed in an outpatient or home setting, which uses the patient's peritoneal membrane as a dialyzer.

0 - General Classification	CCPD/OP OR HOME
1 - CCPD/Composite or other rate	CCPD/COMPOSITE
2 - Home Supplies	CCPD/HOME/SUPPL
3 - Home Equipment	CCPD/HOME/EQUIP
4 - Maintenance 100%	CCPD/HOME/100%
5 - Support Services	CCPD/HOME/SUPSERV
9 -Other CCPD Dialysis	CCPD/HOME/OTHER

088X - Miscellaneous Dialysis - Charges for Dialysis services not identified elsewhere.

0 - General Classification	DAILY/MISC
1 – Ultrafiltration	DAILY/ULTRAFILT
2 – Home dialysis aid visit	HOME DIALYSIS AID VISIT
9 -Other misc. Dialysis	DAILY/MISC/OTHER

HCPCS/Rates

All ESRD hemodialysis claims must include HCPCS 90999 on the line reporting revenue code 082x. All AKI claims must include HCPCS G0491.

Modifiers

Modifiers are required with ESRD Billing for reporting the adequacy of dialysis and the vascular access. For information on modifiers required for these quality measures see 50.9 of this chapter.

For information on reporting modifiers applicable to the Erythropoietin Stimulating Agents refer to section 60.4 of this chapter.

Route of administration modifiers required are JA, JB and JE.

For information on reporting the AY modifier for services not related to the treatment of ESRD, see sections 60.2.1.1 - Separately Billable ESRD Drugs and 60.1 - Lab Services.

For information on reporting the CG modifier for additional treatments provided without medical justification, see section 10.1 of this chapter.

For information on reporting the JW and JZ modifiers for drugs and biologicals see section 50.2.

ESRD facilities should not bill any renal dialysis service with the AX modifier, unless otherwise notified by CMS, for dates of service on or after July 1, 2026.

Service Date

Report the line item date of service for each dialysis session and each separately payable item or service.

Service Units

Hospital-based and independent renal facilities must complete this item. The entries quantify services by revenue category, e.g., number of dialysis treatments. Units are defined as follows:

0634 - Erythropoietin (EPO) - Administrations, i.e., the number of times an injection of less than 10,000 units of EPO was administered. For claims with dates of service on or after January 1, 2008, facilities use the units field as a multiplier of the dosage description in the HCPCS to arrive at the dosage amount per administration.

0635 - Erythropoietin (EPO) - Administrations, i.e., the number of times an injection of 10,000 units or more of EPO was administered. For claims with dates of service on or after January 1, 2008, facilities use the units field as a multiplier of the dosage description in the HCPCS to arrive at the dosage amount per administration.

082X - (Hemodialysis) - Sessions

083X - (Peritoneal) - Sessions

084X - (CAPD) – Per Day

085X - (CCPD) – Per Day

Effective April 1, 2007, the implementation of ESRD line item billing requires that each dialysis session be billed on a separate line. As a result, claims with dates of service on or after April 1, 2007 should not report units greater than 1 for each dialysis revenue code line billed on the claim.

Total Charges

Hospital-based and independent renal facilities must complete this item. Hospital-based facilities must show their customary charges that correspond to the appropriate revenue code. They must not enter their composite or the EPO` rate as their charge. Independent facilities may enter their composite and/or EPO rates.

Neither revenue codes nor charges for services included in the composite rate may be billed separately, but should be itemized on ESRD facility claims as appropriate. Hospitals must maintain a log of these charges in their records for cost apportionment purposes.

Services which are provided but which are not included in the composite rate may be billed as described in sections that address those specific services.

The last revenue code entered in as 000l represents the total of all charges billed.

Principal 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. For patients with AKI see section 40 of this chapter.

Other Diagnosis Code(s)

For claims with dates of service on or after January 1, 2011 renal dialysis facilities report the appropriate diagnosis code(s) for comorbidity conditions eligible for an adjustment.

50.6.2 - Payment for Hemodialysis Sessions

(Rev.13588; Issued:01-28-26; Effective: 07-01-26; Implementation:07-06-26)

Hemodialysis is typically furnished three times per week in sessions of three to five hours duration. Each hemodialysis session equals one PPS base rate payment. Therefore, three sessions per week is three PPS base rate payments. Dialysis furnished at this frequency is paid without the need for a secondary diagnosis to justify payment. The justification must support the medical necessity of the service(s) being rendered.

Hemodiafiltration sessions are paid identically to hemodialysis sessions.