CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 13909	**Date: August 7, 2026**
	Change Request 14551

NOTE: This Transmittal is no longer sensitive and is being re-communicated November 13, 2026. The Transmittal Number, date of Transmittal and all other information remains the same. This instruction may now be posted to the Internet.

SUBJECT: Implementation of System Changes for the End Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Payment for Renal Dialysis Services Furnished to Individuals with Acute Kidney Injury (AKI) for Calendar Year (CY) 2027

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to implement system changes required for proposed policies discussed in the CY 2027 ESRD PPS proposed rule. Updates to the Internet Only Manual (IOM), Pub. 100-04, Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and Outpatient Prospective Payment System (OPPS)) and Chapter 8 - Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims are also included in this CR.

EFFECTIVE DATE: January 1, 2027
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 2027

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	4/50.1/Outpatient Provider Specific File
R	8/20/End Stage Renal Disease Prospective Payment System (ESRD PPS) Per Treatment Payment Amount

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: 13909	Date: August 7, 2026	Change Request: 14551

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II. GENERAL INFORMATION

A. Background: The purpose of this CR is to implement policies proposed in the CY 2027 ESRD PPS proposed rule that would be effective January 1, 2027. Updates to the IOM, Pub. 100-04, Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS) and Chapter 8 - Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims are also included in this CR.

B. Policy: Changes to Low Volume Payment Adjustment (LVPA) Policy

Beginning in CY 2027, CMS is proposing to establish six (6) tiers for LVPA payment based on treatment volume with different payment adjustments for each tier. If finalized, CMS would expand the LVPA to ESRD facilities which furnish fewer than 8,000 treatments per year. An ESRD facility that meets all the existing LVPA criteria at § 413.232(b) will receive a payment adjustment based on their annual treatment count. A facility's annual treatment count will be based on the median treatment volume over its most recent prior three (3) cost reporting years. Additional instructions for MACs to apply the appropriate tier to an ESRD facility will be provided in the ESRD PPS Annual Update CR. The six treatment volume tiers are as follows:

Tier 1 (0-2,999 treatments per year): 36.8 percent.
Tier 2 (3,000-3,999 treatments per year): 24.9 percent.
Tier 3 (4,000-4,999 treatments per year): 17.3 percent.
Tier 4 (5,000-5,999 treatments per year): 12.0 percent.
Tier 5 (6,000-6,999 treatments per year): 8.0 percent.
Tier 6 (7,000-7,999 treatments per year): 5.0 percent.

Effective January 1, 2027, if these proposed policy changes to the LVPA are finalized, the Outpatient Provider Specific File (OPSF) field that indicates an ESRD facility's low-volume status must change to

accept a range of valid values from “1” through “6” that indicate whether the facility is low-volume and the tier to which it is assigned.

Lastly, CMS is proposing to apply the low-volume adjustment to pediatric claims submitted by low-volume facilities. Additional instructions will be provided in the ESRD PPS Annual Update CR.

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	
14551.1	The contractor shall revise the OPSF field 57 (**field must be alpha/numeric)** File Position 57 X(1) Special Locality Indicator Indicates the type of special locality provision that applies. **For End Stage Renal Disease (ESRD) facilities:** **Dates of service prior to Jan 1, 2027:** Value blank = No LVPA Value 1, 2 = equals tier for low volume adjustment applicable **Dates of service on or after Jan 1, 2027**: Value blank = No LVPA Value 1, 2, 3, 4, 5, 6 = equals tier for low volume adjustment applicable **Note**: A/B MACs Part A will be provided additional instructions for applying the appropriate tier in the ESRD PPS Annual Update CR.	X				X				ESRD Pricer, PDS
14551.1.1	The contractor shall send the tier value in the OPSF field 57 when applicable to the					X				ESRD Pricer, PDS

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	ESRD Pricer.									
14551.1.2	The contractor shall remove the tier indicator when refreshing the OPSF for the start of the new calendar year.	X				X				
14551.2	The contractor shall make any required edits for reason codes related to this CR.					X				

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 50.3.3 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

V. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

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(Rev. 13909; Issued: 08-07-26)

Transmittals for Chapter 4

50.1 - Outpatient Provider Specific File

(Rev. 13909; Issued: 08-07-26; Effective: 01-01-27; Implementation: 01-04-27)

The Outpatient Provider Specific File (OPSF) contains the required information about each provider to enable the pricing software to calculate the payment amount. Data elements and formats are shown below. Contractors must maintain the accuracy of the data, and update the file as changes occur in data element values, e.g., changes in metropolitan statistical area (MSA), bed size, cost to charge ratio. An update is accomplished by preparing and adding an additional complete record showing new current values and the effective date of the change. The old record is retained without change.

Contractors must also furnish CMS a quarterly file in the same format.

NOTE: All data elements, whether required or optional, must have a default value of "0" (zero) if numerical, or blank if alphanumerical.

File Position	Format	Title	Description
1-10	X(10)	National Provider Identifier (NPI)	Alpha-numeric 10 character provider number.
11-16	X(6)	Provider Oscar Number	Alpha-numeric 6 character provider number.
17-24	9(8)	Effective Date	Must be numeric, CCYYMMDD. This is the effective date of the provider's first OPPS period. For subsequent OPPS periods, the effective date is the date of a change to the PROV file. If a termination date is present for this record, the effective date must be equal to or less than the termination date.
25-32	9(8)	Fiscal Year Beginning Date	Must be numeric, CCYYMMDD. Month: 01-12 Day: 01-31 The date must be greater than 19990630.
33-40	9(8)	Report Date	Must be numeric, CCYYMMDD. Month: 01-12 Day: 01-31 The created/run date of the PROV report for submittal to CO.
41-48	9(8)	Termination Date	Must be numeric, CCYYMMDD. Must be zeroes or contain a termination date. (Once the official "tie-out" notice from CMS is received). Must be equal to or greater than the effective date. (Termination date is the date on which the reporting contractor ceased servicing the provider in question).

49	X(1)	Waiver Indicator	Enter a "Y" or "N." Y = waived (provider is not under OPPS) For End Stage Renal Disease (ESRD) facilities provider waived blended payment, pay full PPS. N = not waived (provider is under OPPS) For ESRD facilities provider did not waive blended payment. Pay according to transitional payment method for ESRD PPS through 2013.
50-54	9(5)	Intermediary Number	Enter the Contractor #.
55-56	X(2)	Provider Type	This identifies providers that require special handling. Enter one of the following codes as appropriate. 00 or blanks = Short Term Facility 02 Long Term 03 Psychiatric 04 Rehabilitation Facility 05 Pediatric 06 Reserved 07 Rural Referral Center 08 Indian Health Service 13 Cancer Facility 14 Medicare Dependent Hospital (during cost reporting periods that began on or after April 1, 1990. 15 Medicare Dependent Hospital/Referral Center (during cost reporting periods that began on or after April 1, 1990. Invalid October 1, 1994 through September 30, 1997). 16 Re-based Sole Community Hospital 17 Re-based Sole Community Hospital /Referral Center 18 Medical Assistance Facility 21 Essential Access Community Hospital 22 Essential Access Community Hospital/Referral Center 23 Rural Primary Care Hospital 24 Rural Emergency Hospitals 32 Nursing Home Case Mix Quality Demonstration Project – Phase II 33 Nursing Home Case Mix Quality Demonstration Project – Phase III – Step 1 34 Free-standing Opioid Treatment Program 35 Hospice 36 Home Health Agency 37 Critical Access Hospital

			38 Skilled Nursing Facility (SNF) – For non-demo PPS SNFs – effective for cost reporting periods beginning on or after July 1, 1998 40 Hospital Based ESRD Facility 41 Independent ESRD Facility 42 Federally Qualified Health Centers 43 Religious Non-Medical Health Care Institutions 44 Rural Health Clinics-Free Standing 45 Rural Health Clinics-Provider Based 46 Comprehensive Outpatient Rehab Facilities 47 Community Mental Health Centers 48 Outpatient Physical Therapy Services 49 Psychiatric Distinct Part 50 Rehabilitation Distinct Part 51 Short-Term Hospital – Swing Bed 52 Long-Term Care Hospital – Swing Bed 53 Rehabilitation Facility – Swing Bed 54 Critical Access Hospital – Swing Bed
57	X(1)	Special Locality Indicator	Indicates the type of special locality provision that applies. For End Stage Renal Disease (ESRD) facilities: Dates of service prior to Jan 1, 2025: value "Y" equals low volume adjustment applicable. Dates of service on or after Jan 1, 2025: Value blank = No low volume adjustment applicable Value 1 or 2 = tier number applicable for low volume adjustment *Dates of service on or after Jan 1, 2027:* *Value blank = No low volume adjustment applicable* *Value 1, 2, 3, 4, 5, or 6 = tier number applicable for low volume adjustment*
58	X(1)	Change Code For Wage Index Reclassification	Enter "Y" if the hospital's wage index location has been reclassified for the year. Enter "N" if it has not been reclassified for the year. Adjust annually. Does not apply to ESRD Facilities.
59-62	X(4)	Actual Geographic Location—MSA	Enter the appropriate code for MSA, 0040–9965, or the rural area, (blank) (blank) 2-digit numeric State code, such as _ _ 3 6 for Ohio, where the facility is physically located.

63-66	X(4)	Wage Index Location—MSA	The appropriate code for the MSA, 0040-9965, or the rural area, (blank)(blank) (2 digit numeric State code) such as _ _ 3 6 for Ohio, to which a hospital has been reclassified for wage index. Leave blank or enter the actual location MSA if not reclassified. Does not apply to ESRD Facilities.
67-70	9V9(3)	Payment-to-Cost Ratio	Enter the provider's payment-to-cost ratio. Does not apply to ESRD Facilities.
71-72	9(2)	State Code	Enter the 2-digit state where the provider is located. Enter only the first (lowest) code for a given state. For example, effective October 1, 2005, Florida has the following State Codes: 10, 68 and 69. Contractors shall enter a "10" for Florida's State Code. List of valid State Codes is located in Pub. 10007, Chapter 2, Section 2779A1.
73	X(1)	TOPs Indicator	Enter the code to indicate whether TOPs applies or not. Y = qualifies for TOPs N = does not qualify for TOPs

74	X(1)	Quality Indicator Field	Hospital: Enter the code to indicate whether the hospital meets data submission criteria per HOP QDRP requirements. 1 = Hospital quality reporting standards have been met or hospital is not required to submit quality data (e.g., hospitals that are specifically excluded from the IPPS or which are not paid under the OPPS, including psychiatric, rehabilitation, long-term care and children's and cancer hospitals, Maryland hospitals, Indian Health Service hospitals, or hospital units; or hospitals that are located in Puerto Rico or the U.S. territories). The reduction does not apply to hospices, CORFs, HHAs, CMHCs, critical access hospitals or to any other provider type that is not a hospital. Blank = Hospital does not meet criteria. Independent and Hospital-based End Stage Renal Disease (ESRD)Facilities: Enter the code applicable to the ESRD Quality Incentive Program (QIP): Blank = no reduction 1 = ½ percent payment reduction 2 = 1 percent payment reduction 3 = 1 ½ percent payment reduction 4 = 2 percent payment reduction * Please refer to file position 101 for ESRD Children's Hospitals Quality Indicator.
75	X(1)	Filler	Blank.
76-79	9V9(3)	Outpatient Cost-to-Charge Ratio	Derived from the latest available cost report data. See §10.11 of this chapter for instructions on how to calculate and report the Cost-to-Charge Ratio. Does not apply to ESRD Facilities.
80-84	X(5)	Actual Geographic Location CBSA	00001-89999, or the rural area, (blank) (blank) (blank) 2 digit numeric State code such as _ _ _ 3 6 for Ohio, where the facility is physically located.

85-89	X(5)	Wage Index Location CBSA	Enter the appropriate code for the CBSA, 0000189999, or the rural area, (blank)(blank)(blank) (2 digit numeric State code) such as _ _ _ 3 6 for Ohio, to which a hospital has been reclassified due to its prevailing wage rates. Leave blank or enter the Actual Geographic Location CBSA, if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank. Does not apply to ESRD Facilities.
90-95	9(2) V9(4)	Special Wage Index	Enter the special wage index that certain providers may be assigned. Enter zeroes unless the Special Payment Indicator equals a "1" or "2."
96	X(1)	Special Payment Indicator	The following codes indicate the type of special payment provision that applies. Blank = not applicable Y = reclassified 1 = special wage index indicator 2 = both special wage index indicator and reclassified D = Dual Reclassified
97-100	9(4)	Reduced Coinsurance Trailer Count	Enter the number of APCs the provider has elected to reduce coinsurance for. The number cannot be greater than 999.
101	X(1)	Quality Indicator ESRD Children's Hospitals	Children's Hospitals for End Stage Renal Disease (ESRD) Facilities: Enter the code applicable to the ESRD Quality Incentive Program (QIP): Blank = no reduction 1 = ½ percent payment reduction 2 = 1 percent payment reduction 3 = 1 ½ percent payment reduction 4 = 2 percent payment reduction
102-105	9V9(3)	Device department's Cost-to-Charge Ratio	Derived from the latest available cost report data. Does not apply to ESRD Facilities.
106-112	X(7)	Carrier/Locality code	The carrier/locality code for the provider service facility. The first five positions represent the carrier code and the last two positions represent the locality code.
113-117	9(5)	County Code	Enter the County Code. Must be 5 numbers.

118-122	X(5)	Payment CBSA	Enter the appropriate code for the CBSA, 0000189999, or the rural area, (blank)(blank)(blank) (2 digit numeric State code) such as _ _ _ 3 6 for Ohio, to which a hospital has been reclassified due to its prevailing wage rates. Leave blank or enter the Actual Geographic Location CBSA, if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank. Does not apply to ESRD Facilities.
123-128	9V9(5)	Payment Model Adjustment (PMA)	Derived from payment model Technical Direction Letter.
129-133	9V9999	Medicare Performance Adjustment (MPA)	Enter the MPA percentage calculated and published by the Centers for Medicare & Medicaid Services (CMS).
134-139	9(2) V9(4)	Supplemental Wage Index	Enter the supplemental wage index that certain providers may be assigned. Enter zeroes if it does not apply.
140-140	X(1)	Supplemental Wage Index Flag	Enter the supplemental wage index flag: 1=Prior Year Wage Index 2=Future use 3=Future use Enter blank if it does not apply.
141-162	X(22)	FILLER	

The contractor enters the number of APCs for which the provider has elected to reduce coinsurance. Cannot be greater than 999. Reduced Coinsurance Trailer Record - Occurs 0-999 times depending on the reduced Coinsurance Trailer Count in positions 97-100. Due to system's capacity limitations the maximum number of reduced coinsurance trailers allowable is 999 at this time.

Medicare Claims Processing Manual

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

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(Rev. 13909; Issued: 08-07-26)

Transmittals for Chapter 8

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

(Rev. 13909; Issued: 08-07-26; Effective: 01-01-27; Implementation: 01-04-27)

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)
- *Low-Volume ESRD Facility (not applicable for pediatric patients for claims with dates of service prior to January 1, 2027)*

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

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 *8,000* treatments in each of the three cost report years preceding the payment year and has not open*ed*, 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. *Effective January 1, 2027, all ESRD patient claims (adult and pediatric) are 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 $*138.22* 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.

Effective January 1, 2025, oral-only renal dialysis *drugs are* included in the *ESRD* PPS.

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 billed 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).