USER'S MANUAL FOR THE
END STAGE RENAL DISEASE PPS PC PRICER

The End Stage Renal Disease PPS PC PRICER is a tool used to estimate ESRD PPS payments. The ESRD PPS PC Pricer does not interact with active beneficiary files or Medicare eligibility files. The accuracy of the estimated claim payment is based upon the information entered on the ESRD PC Pricer data entry screen. The estimated claim payment may not be precise to how payments are determined in the Medicare claims processing system.

PROVIDER INFORMATION FIELD DESCRIPTIONS

- **Provider Type** (Required field) **-** For this field, select "H" for hospital based facility or "I" for Independent facility.

- **CBSA** (Required field) **-** Enter the CBSA (Core Based Statistical Area) for the location of the facility. For claims with dates of service from 2005 through 2008 the MSA (Metropolitan Statistical Area) is required.

- **Special Wage Index** (Optional field) **-** This field is used to price claims with a different wage index than the wage index that is present on the facility's CBSA (Core Based Statistical Area) in the Wage Index table.

  Select "Yes" **-** If the wage index that is present on the facility's CBSA (Core Based Statistical Area) in the Wage Index table does not match the wage index used to price claims.

  Select "No" **-** If not applicable.

- **Special Wage Index Value** (Optional field) **-** If the "special wage index" field is "yes" then enter the wage index value in this field.

- **Waived blended payment** (Required field) **-** ESRD providers were given a one- time chance to opt

out of the 4 year transitioning period and begin receiving full payment under the PPS (Prospective Payment System).

Select "Yes" if you opted out of the transitional payment and are receiving fully payment under the PPS.

Select "No" if you did not opt out of the transitional payment and are receiving a blended payment of the old composite rate payment and the PPS.

- **Low Volume Provider** (Optional field) **-** ESRD providers meeting the requirements for the low volume provider designation should select "Yes" to receive the low volume adjustment. All other providers may select "No" or leave the field blank.

- **QIP Reduction Factor (**Optional field) **-** Applicable to claims with dates of service on or after January 1, 2012**.** ESRD providers that fail to meet or exceed a total performance score would qualify for an estimated payment reduction percentage (up to two percent) under the ESRD QIP.

  Select the appropriate code for the applicable QIP Reduction factor. Defined as follows:
  0.5% Payment Reduction   1
  1.0% Payment Reduction   2
  1.5% Payment Reduction   3
  2.0% Payment Reduction   4

  All other providers may leave the field blank.

PATIENT INFORMATION FIELD DESCRIPTIONS

- **Birthdate** (Required field) **-** Enter the patient's date of birth using two digits for month and day and four digits for the year format (MM/DD/YYYY.)

- **Weight In Kilograms** (Required field) **-** Enter the patient's weight in kilograms. Entry of the decimal point is required.

- **Height In Centimeters (**Required field) - Enter the patient's height in centimeters. Entry of the decimal point is required.

- **Dialysis Start Date on Form 2728 within 120 days of line item date of service** (Optional field) **-**

  Select "Yes" for a new patient within the first 120 days of their initial start of dialysis for the onset of dialysis adjustment.

  Select "No" if not applicable or leave the field blank.

- **Unique Patient ID** (Optional field) **-** The provider may enter any information to identify the patient for their own records or leave the field blank.

CLAIM INFORMATION FIELD DESCRIPTIONS

- **Line Item Date Of Service** (Required field) **-** Enter the date of treatment using two digits for month and day and four digits for year format (MM/DD/YYYY.)

  Note: All treatments on the claim will receive the same reimbursement unless the patient was

receiving the onset of dialysis adjustment and exhausted the 120 days during the billing period.

- **Condition Code** (Required field) - Select the appropriate condition code:

  Select "73" to receive a rate with a training adjustment when the treatment included training.

  Select "74" for a home dialysis patient.

  Select "84" for acute kidney injury.

  Select "N/A" for all other in-facility treatments

- **Revenue Code** (Required field) **-** Select the appropriate revenue code for the treatment modality.

  821 Hemodialysis

  831 Peritoneal dialysis

  841 Continuous Ambulatory Peritoneal Dialysis (CAPD)

  851 Continuous Cycling Peritoneal Dialysis (CCPD)

  881 Ultrafiltration

- **Total Medicare Allowed Payment For Outlier Consideration** (Optional field) - For calculation of a possible outlier payment, the provider enters the payment amount that would have been expected for separately billable services under the composite rate system. Decimal point required.

- **Total TDAPA Amount** (Optional field) - For calculation of the Transitional Drug Add-On Payment Adjustment (TDAPA), the provider enters the amount captured in value code Q8 for HCPCS codes J0604 and J0606.

  The TDAPA amount is calculated using the following formula:

  Q8 = (units * ASP/unit) * Number of dialysis treatments for month

  Please refer to CMS Transmittal 1881, Change Request 10065, dated August 4, 2017 for additional details.

- **Number of Dialysis Sessions in the Billing Period** (Required field) - Enter the total number of dialysis sessions to be reported on the claim. This field must be two digits (for example 3 sessions would be 03).

- **Comorbidities** (Optional field) - To receive a rate including an adjustment for a comorbid condition, select the check box next to the applicable comorbidity field. When multiple comorbidities are applicable, only the highest paying comorbid adjustment is applied to the payment.