ESRD 90999 – No Modifier (Weekly and Monthly) Limits

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In a conflict, federal and state guidelines, as applicable, and the member's benefit plan document supersede the information in this policy. Also, to the extent of conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval. If there is a state exception, please refer to the state exception table listed below.

Policy Overview

End Stage Renal Disease (ESRD) occurs from the destruction of normal kidney tissues over a prolonged period. Dialysis is a process by which waste products are removed from the body by diffusion from one fluid compartment to another across a semi-permeable membrane.

ESRD facilities furnishing dialysis treatments in-facility or in the beneficiary's home are typically paid for the normal frequency of Dialysis which is 3 treatments per week up to 13/14 total visits per month. Payment for additional treatments, defined as any treatments in excess 3 treatments per week, may be considered for payment based on the Patient's Plan of Care or other medical documentation.

Reimbursement Guidelines

For monthly claims submitted with Bill Type 72X and Revenue Codes 0821 and 0881, the approach to billing **per line** are as follows:

- For dialysis sessions that have been furnished 3 times (3X) per week, each line should be billed with CPT code 90999 without any modifiers appended.

  Example: A hemodialysis-prescription states 3 times (3X) per week and each session is furnished, all sessions should be billed as 90999 (no modifier appended) and will be paid as routine conventional dialysis up to 13/14 per month.

- For dialysis sessions that have been furnished in addition to the 3 sessions per week, but does not include supporting medical documentation (*e.g., shorter, more frequent treatments furnished for the convenience of patient or staff*) indicating a reasonable and necessary determination for payment:
- Each line must be billed as 90999 CG.
- For each dialysis session furnished in addition to 3 sessions per week which does include medical documentation supporting a reasonable and necessary determination for payment, each line for these services should be billed as 90999 KX.
    - These sessions must be reasonable and necessary for additional payment based on clinical conditions.
    - The KX modifier serves as confirmation that services are medically necessary after the beneficiary has exceeded the KX modifier threshold of incurred expenses.
    - Omission of the KX modifier will result in no additional payment for the line item.

The expectation is that these scenarios will be seen on monthly or weekly claims (i.e., claims with 90999 lines only) or those with lines of 90999 mixed with KX modifier appended.

This concept evaluates the frequency of Hemodialysis based on two reports: one monthly and the other weekly.

1. The ESRD Weekly Limit report identifies ESRD visits rendered for members more than the allowed 3 visits per week without the KX modifier appended as payment for Outpatient End Stage Renal Disease Related Services which requires a KX modifier when billed greater than 3 times per week.
2. The ESRD Monthly Limit report identifies ESRD visits rendered for members more than the allowed 13/14 visits per month without the KX modifier appended as payment for Outpatient End Stage Renal Disease Related Services requires a KX modifier when billed greater than 13/14 per month.

Weekly Limit Concept Specific Inclusions:

- Claim Type: UB04
- Same Member
- Bill Type: 72X
- LOB: ALL
- Revenue Code(s): 821 or 881
- CPT Code: 90999
- Missing Modifier: KX
- **Weekly Over Limit**: Greater than 3 per week *(Weekly Service)*
- Flagged for reference:
    - Monthly Limits for reference and will overlap with monthly report.
        - Monthly Over Limit: Greater than 13 services for 30-day month and 14 services for 31-day month (*Monthly Service)* For the claims in this report that state over limit in this column – are they also captured in the monthly limit report?
        - Monthly Within Limit: Less than or equal to 13 services for 30-day month and 14 services for 31-day month *(Monthly Service)*
    - CKD vs AKI History:
        - AKI History: Member has a historical claim with an N17 DX
        - CKD History: Member has a historical claim with an N18 DX

Monthly Limit Concept Specific Inclusions:

- Claim Type: UB04
- Bill Type: 72X
- LOB: ALL
- Revenue Code(s): 821 or 881 (hemodialysis sessions)
- CPT Code: 90999
- Missing Modifier: KX
- **Monthly Over Limit:** Greater than 13/14 per monthly
    - Monthly Limits for reference
        - **Monthly Over Limit**: Greater than 13 services for 30-day month and 14 services for 31-day month (*Monthly Service)*
        - **Monthly Within Limit**: Less than or equal to 13 services for 30-day month and 14 services for 31-day month (*Monthly Service)*
- Flagged for reference:
    - CKD vs AKI History:
    - AKI History: Member has a historical claim with an N17 DX
    - CKD History: Member has a historical claim with an N18 DX

Supplemental Information

Definitions

Term	Definition
AKI	Acute Kidney Injury
CKD	Chronic Kidney Disease
CMS	the Centers for Medicare & Medicaid Services. It is a federal agency within the United States Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program (CHIP), and health insurance portability standards.
CPT	Current Procedural Terminology
ESRD	End Stage Renal Disease
ODM	Ohio Department of Medicaid

State Exceptions

State	Exception

ALL States	**Weekly Limit Concept Specific Exclusions**:
	• Excluded claim lines billed with modifiers: KX
	• Excluded Condition Codes:
	  ○ 73 (self-care in training)
	  ○ 87 (self-care retraining)
	
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	• Excluded claim lines billed with modifiers: KX
	• Excluded Condition Codes:
	  ○ 73 (self-care in training)
	  ○ 87 (self-care retraining)

IL	Concept approved to become effective starting on DOS (Date of Service) 6/1/2022
OH	**Exclude** Custom Contracts and LOAs for Marketplace and Medicare **Exclude** Medicaid LOB (Lines of Business) ○ ODM does not recognize KX modifier on ESRD
TX	**Exclude Medicaid LOB:** This policy is specific to CPT 90999 and KX modifier weekly limit. Texas Medicaid does not have this limitation and the KX Modifier is not used on ESRD. This limitation is Medicare specific and not part of the composite rate reimbursement methodology, Method I or Method II. The 90999 with KX limit does not apply to Texas Medicaid

Documentation History

Type	Date	Action
Effective Date	04/26/2024	New Policy
Revised Date	12/16/2024	Updated templates

References

This policy was developed using.

- CMS
- State Medicaid Regulatory Guidance
- State Contracts

State/Agency	Document Name/Description	Link/Document
CMS	Billing and Coding: Frequency of Hemodialysis	Billing and Coding: Frequency of Hemodialysis (A55703) Billing and Coding: Frequency of Hemodialysis (A55672) Frequency of Hemodialysis (L34575)

***CODING DISCLAIMER**. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.*