



Dr. Earl Berman  
CGS Administrators, LLC  
Two Vantage Way  
Nashville, TN 37228

**RE: Local Coverage Article: Billing and Coding: Frequency of Hemodialysis**

Dear Dr. Berman:

The Alliance for Home Dialysis (Alliance) is writing to raise concerns with policies being implemented across the country that have the potential to limit access to vital treatment options for dialysis patients. Specifically, several Medicare Administrative Contractors (MACs) have made changes to the coverage articles that accompany their Local Coverage Determination (LCD) to clarify billing and coding for the frequency of hemodialysis. We are sharing our concerns with you so that CGS can take them into account when considering any potential updates to its own coverage article and LCD.

Specifically, we are concerned that, despite the changes, the coverage articles do not appropriately reflect the appropriate corresponding LCDs, or Centers for Medicare and Medicaid Services (CMS) payment policy for more frequent dialysis. Therefore, they create ambiguity that may result in disruptions or reduced access to therapy for patients on home hemodialysis. We also believe these coverage articles will frustrate new efforts by the Department of Health and Human Services, and CMS to dramatically increase home dialysis uptake.

The Alliance is a coalition of kidney dialysis stakeholders representing patients, clinicians, providers, and industry. We have come together to promote activities and policies to facilitate treatment choice in dialysis care, while addressing systemic barriers that limit access for patients and their families to the many benefits of home dialysis.

While we were initially concerned the draft LCD would disproportionately impact home hemodialysis patients for whom more frequent dialysis is often medically justified, we believe that the final LCD strikes the right balance between proper documentation of medical justification and appropriate access to therapy for home patients.

The Alliance remains concerned, however, that the associated coverage article does not accurately reflect the policy as drafted in the LCD. Nor does the coverage article accurately

reflect CMS coverage policy for additional dialysis treatments. CMS policy continues to be that Medicare will pay for additional dialysis treatments when it is medically necessary. Furthermore, CMS policy does not arbitrarily limit coverage to acute or short-term situations.

The Alliance is deeply concerned that the recent update to the coverage article did not address the suggestion in instruction number 3 that use of the KX modifier may be appropriate only “for additional payments on an acute or short-term basis.” The instruction conflicts with the plain language of the LCD, which states:

“However, on occasion, acute, and occasionally **chronic**, conditions may require additional sessions during the month. These may be considered for additional payment.”

The Alliance believes that as currently written, the coverage article is also confusing as to the appropriate use of the KX modifier. The Alliance recommends addressing revising the instructions as follows:

**1. For all dialysis sessions outlined in the dialysis prescription, including sessions exceeding 3 times per week where no additional documentation of medical necessity for the additional treatments is provided**, each line should be 90999 without any modifiers appended. For example, should the hemodialysis prescription outline 3 times (3 X) per week, all of these sessions should be billed as 90999 (no modifier appended) and will be paid as routine conventional dialysis up to 13/14 per month. It would be inappropriate to apply a modifier. For those prescriptions for more than 13/14 per month at otherwise normal parameters (i.e., 4 times [4 X] per week or more), each line should be billed as 90999 without a modifier as well. All will be paid as per the limits of 13/14 per month found in the IOM 100-02, *Medicare Benefit Policy Manual*, Chapter 11, Section 50.

**2. For dialysis sessions considered not to meet the medical justification for payment**, any given line for these sessions should be billed as 90999 CG. For example, the dialysis prescription includes those treatments based on known inadequate treatments, planned short treatments, more frequent treatments for convenience of the patient or staff, etc. These treatments do not meet medical justification for additional payment. The CG modifier should be applied on the lines indicating the extra sessions did not meet medical justification for payment. These specific lines will be denied as not medically justified. Please refer to CR 9989, Implementation of Modifier CG for Type of Bill 72X, dated May 12, 2017.

**3. For dialysis sessions reasonable and necessary beyond outside the usual 3 times per week dialysis prescription**, i.e., for medical conditions that may be appropriate for additional payments on an acute, ~~or~~ short term, or ongoing basis, and that have supporting documentation of medical necessity (e.g., through documents from recent hospital care, office visits, dialysis progress notes or MCP visits), the lines billed for these DOS should be billed as 90999 KX. These would include those medical conditions outlined in the L37475. These sessions are felt to be reasonable and necessary for additional payment based on clinical conditions. On these claims, the 90999 lines without a modifier will be paid as 3 X per week and those lines with 90999 KX will be considered for additional payments. However, omission of the KX modifier will have all sessions paid as conventional dialysis as 3 X per week. For diagnoses not listed in this article but felt to be reasonable and necessary, the KX modifier should be

appended as well. A denial will occur on these lines, but the redetermination process (an appeal) will be available to submit supportive documentation for review.

The Alliance appreciates the need to develop an efficient process for evaluating claims for additional dialysis sessions, and we would appreciate the changes made to the final LCD to better reflect the need for some patients to dialyze more frequently. We urge CGS to consider that while the LCD ultimately reflects the policy for payment of additional dialysis sessions, a coverage article that does not accurately reflect the policy is equally problematic. We urge CGS to revise the coverage article to clarify appropriate use of the KX modifier as well as to more accurately reflect CMS coverage policy for additional dialysis treatments for chronic conditions.

Should you have any questions, please feel free to contact Michelle Seger at [michelle@homedialysisalliance.org](mailto:michelle@homedialysisalliance.org).

Sincerely,

A handwritten signature in cursive script that reads "Elizabeth Lee". The signature is written in black ink and is positioned above the printed name and title.

Elizabeth Lee  
Executive Director



**Alliance for Home Dialysis Endorsing Members**

**American Association of Kidney Patients  
American Kidney Fund  
American Nephrology Nurses Association  
American Society of Nephrology\*  
American Society of Pediatric Nephrology  
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