JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Reimbursement Policies** **Reimbursement Policies**	*Policy Number*	RPC.052
		Effective Date	05/30/2026
		Approval Date	02/10/2026
	Subject **USFHP End Stage Renal Disease & Related Services**	*Supersedes Date*	N/A
		Original Date	05/30/2026
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This document applies to the following Participating Organizations:

Johns Hopkins Medical Services Corporation (USFHP)

Keywords: ESRD

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I. POLICY SCOPE AND APPLICABILITY

About This Policy

This reimbursement policy outlines Johns Hopkins Health Plans (JHHP; the "Plan") requirements for claims submitted by participating and non-participating providers on CMS-1500/837P and UB-04/837I claim forms. The JHHP Reimbursement Policy Reference Guide serves as a key reference for this and other related reimbursement policies. This policy is current as of the publication date but is not exhaustive and does not address every billing or coding scenario.

Policy Provisions & Limitations

All provisions in this policy may be subject to changes in CMS regulations, federal and state laws, AMA CPT® guidelines, official coding updates, and contractual obligations applicable to the USFHP line of business. The inclusion or omission of specific language or guidance does not waive or limit the applicability of other relevant billing, coding, documentation, coverage, or payment requirements.

II. PURPOSE

This policy outlines the Plan's most common requirements for documentation, coding, billing, and reimbursing of items and services related to the treatment of End Stage Renal Disease (ESRD) to support accurate claims processing; it is not meant to be all-inclusive, as there may be other ESRD-related services that are billed using codes that may not be reflected within this policy.

III. GENERAL REPORTING & REIMBURSEMENT GUIDELINES

CMS-2728 Reporting Requirements

1. Regardless of the member's age or Medicare eligibility, providers must submit Form CMS 2728 to EQRS (End Stage Renal Disease Quality Reporting System) upon the initial diagnosis of N18.6 (End Stage Renal Disease).
2. Providers shall submit documentation to the Plan confirming successful submission of Form CMS-2728 to EQRS.
3. Once Medicare entitlement is established, Medicare is considered the primary payer.

4. During the coordination period, ESRD-related services may only be reimbursed up to the initial 90 days for USFHP members. Thereafter, claims must be submitted to Medicare for payment.

Reporting & Reimbursement of ESRD Services

1. Consistent with the ICD-10-CM Official Guidelines for Coding and Reporting, diagnosis code N18.6 must be assigned when the provider documents that the patient is diagnosed with ESRD.
   - Diagnosis codes for comorbidities should also be reported on ESRD claims, if applicable. Refer to CMS' Chronic and Acute Comorbidity Categories for applicable diagnosis codes.
2. Claims for covered ESRD-related services are reimbursed in accordance with USFHP plan benefits.
3. To support accurate claims processing and payment of ESRD-related services, the Plan applies the following edits, including but not limited to:
   - NCCI
   - MUE
   - Bundling
   - Frequency (e.g., per day/week/month, per provider, per lifetime)
   - Diagnosis
4. All ESRD services provided to our members must be furnished by a plan-approved authorized provider to be eligible for reimbursement, unless an exception applies.

Facility Reporting Guidelines

1. In accordance with CMS guidance, the Plan requires facilities to report ESRD claims with line-item billing details. Each service shall be submitted on a separate line with the appropriate line-item date of service. All claims shall include, at a minimum and as applicable, the following information:
   - Diagnosis code
   - Revenue code
   - HCPCS/CPT code
   - Type of Bill
   - Condition Code
   - Occurrence Code (must report occurrence code 33 for the first day of coordination period covered by USFHP).
   - Number of units
   - Value Code
   - Modifiers
   - Rendering and billing provider NPI
2. ESRD services are subject to the monthly billing requirements for repetitive services.
3. If multiple codes are needed to represent distinct or independent items, procedures, or services under the same revenue code, providers should repeat the revenue code accordingly.
4. Providers may only report one dialysis condition code per ESRD claim to describe the dialysis setting. If two dialysis settings are used during the month, then two claims must be filed.
5. Consistent with CMS guidance, when reporting 'from' and 'through' dates for dialysis, these dates must reflect the first day dialysis began in the billing month through the last day of dialysis in the billing month.

IV. INAPPROPRIATE BILLING OF SERVICES

1. Claims submitted with missing, incomplete, inaccurate, or invalid information, will be denied.

2. Failure to provide requested or required documentation to the Plan in a timely manner, will result in claims being pended or denied.
3. Claims may be denied when dialysis services on an ESRD claim are reported in the same month as a previously processed or in-process ESRD claim that exceeds the routinely allowed limit for the dates of service.
4. ESRD facility providers may not bill for retraining services of the following (list is not all-inclusive):
   - Installation of home dialysis equipment
   - Furnishing monitoring services
   - Updating treatment records
   - Ordering new supplies
   - To add additional medicine for the treatment of infection

V. TERMS & DEFINITIONS

The terms and definitions that are applicable to this policy are outlined below.

Term	Definition
End-Stage Renal Disease (ESRD)	End Stage Renal Disease (ESRD) occurs from the destruction of normal kidney tissues over a long period of time. Often there are no symptoms until the kidney has lost more than half its function. The loss of kidney function in ESRD is usually irreversible and permanent.
ESRD Facilities (Hospital Based & Independent	An ESRD facility is an entity that provides outpatient maintenance dialysis services, or home dialysis training and support services, or both. ESRD facilities are classified in Section 1881 of the Act and codified in 42 CFR 413.174 as being either hospital-based or independent facilities. There is no distinction between the two facility types for the purposes of payment under the ESRD Prospective Payment System (PPS). • Hospital Based ESRD- As defined in 42 CFR 413.65(a) hospital-based or independent ESRD facilities are not considered part of the hospital and do not qualify as provider-based departments of a hospital. Hospital-based ESRD facilities may be located on a hospital campus and may share certain overhead costs and administrative functions with the hospital. However, hospital-based ESRD facilities have separate provider numbers under which they bill their services, and are subject to unique Conditions for Coverage that differ from hospital Conditions of Participation. • Independent ESRD Facility – Any facility that does not meet the criteria of a hospital-based ESRD facility.
Place of Service (POS)	JHHP recognizes and accepts POS codes from National POS code set, currently maintained by CMS, in terms of HIPAA compliance. POS codes should be used on professional claims to specify the entity where service(s) were rendered.

Renal Dialysis Items and Services	Per CMS, renal dialysis services are all items and services used to furnish outpatient maintenance dialysis to individuals for the treatment of ESRD in the ESRD facility or in a patient's home. Renal dialysis services include but are not limited to: • All items and services included under the composite rate as of December 31, 2010; • Erythropoiesis stimulating agents (ESAs) and their oral or other forms of administration; • Injectable drugs and biologicals and their oral or other forms of administration; • Oral or other forms of non-injectable drugs and biologicals; • Diagnostic laboratory tests; • Home and self-dialysis training; • All supplies, equipment, dialysis machine use and maintenance, support services necessary for the effective performance of a patient's dialysis furnished in the ESRD facility or in a patient's home. • Personnel services; • Administrative services; • Overhead costs; • Monitoring access and related declotting or referring the patient; and • Direct nursing services include registered nurses, licensed practical nurses, technicians, social workers, and dietitians.
Services Provided Under an Arrangement	A Medicare-certified ESRD facility may enter into written arrangements with a second ESRD facility to provide certain covered outpatient dialysis items or services to patients. When services are provided under an arrangement, the first ESRD facility retains professional and financial responsibility for those services and also for obtaining reimbursement for them. The second ESRD facility is permitted to seek payment only from the first ESRD facility and may not bill the patient or JHHP.

VI. REFERENCES

This policy has been developed through consideration of the following:

- American Medical Association (AMA)- CPT® Manual
- CMS End-Stage Renal Disease (ESRD)
- CMS Regulations & Guidance
- JHHP Medical Policies
- JHHP Provider Manuals
- JHHP Reimbursement Policies
- Medicare Benefit Policy Manual Ch. 11- End Stage Renal Disease (ESRD)
- Medicare Claims Processing Manual CH 8- Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims
- Medicare Medically Unlikely Edits (MUEs)
- NCCI Edits
- USFHP Membership Handbook

VII. APPROVALS

This policy is reviewed and updated as regulatory guidance evolves.

Description of Change	Reason for Change	Owner of Change	Date of Change
New policy	N/A	Reimbursement, Authorization, and Configuration (RAC) Workgroup	5/30/2026

VIII. POLICY NOTIFICATION CHART

Applicability	Impact	Notification Recipients
Does this document affect a policy that relates to NCQA?	No	Plan Administration; Quality Improvement; Compliance
Does this document affect a policy that relates to Qlarant/MDH requirements?	No	Plan Administration; Quality Improvement; Compliance
Does this document affect a policy that relates to DHA contractual requirements?	Yes	USFHP Administration; Compliance
Does this document affect a policy that relates to CMS contractual requirements?	No	Plan Administration; Compliance
Does this document affect a policy that requires committee approval?	Yes	Reimbursement, Authorization, and Configuration (RAC) Workgroup
Does this document affect the processes in other operational areas?	Yes	Provider Relations; Utilization Management; Plan Administration; Operations; Compliance