Overview

Acute kidney injury (AKI), formerly known as acute renal failure, is defined as a sudden loss of kidney function. AKI is often identified and usually initially treated in the acute care setting, with the primary goals being to treat the patient and minimize the length of stay. As the patient develops fluid overload, uremic signs and symptoms, and electrolyte abnormalities, hemodialysis may be initiated with low dose or no heparin. During hemodialysis, there is close monitoring, daily laboratory sampling, and administration of blood products as needed. Quality assurance activities in this setting include review of the length of stay and discussion of treatment options, and catheter vs. internal vascular access placement. The team involved is composed of the nephrology nurse, dietitian, social worker, physician, and case manager, if applicable. The social worker has a key role in the management of the patient with AKI and acts as a patient advocate to include patient engagement in the decision-making processes. While monitoring is ongoing, approximately 45 days after the initiation of acute hemodialysis, the patient with AKI should be evaluated for recovery of function or declared as having end stage renal disease (ESRD) by the nephrologist. Medicare payment for acute hemodialysis is provided under the outpatient prospective payment system (OPPS) in a hospital setting (Centers for Medicare and Medicaid Services [CMS], 2012a).

Limited Options

Depending on the limits on the length of stay in the acute facility, the patient with AKI may not recover kidney function before discharge is necessary; therefore, options for hemodialysis treatment outside the hospital should be evaluated. Options for the patient with AKI who needs hemodialysis after discharge from the hospital include:

• Continue to receive hemodialysis in the hospital setting, returning three times a week for treatment, possibly having to travel great distances from home. This could be very cumbersome and costly for the patient, as well as challenging for the hospital to provide hemodialysis in their outpatient department or in the acute inpatient hemodialysis unit, if no outpatient department is available. Payment will be made for Medicare-eligible patients with AKI for outpatient hemodialysis provided in an outpatient department of the hospital. Challenges include difficult or impossible ability to predict workload for scheduling or equipment readiness.

• Be admitted to an ESRD facility for outpatient hemodialysis via a single patient agreement (SPA) between the hospital (payor) and the outpatient hemodialysis center (provider), with full recognition that payment of these charges by Medicare is not an option.

CMS Memo

On April 26, 2012, CMS issued a clarification of policy (CMS, 2012b) and followed that with a frequently asked questions (FAQ) document on July 18, 2012 (CMS, 2012a). The single patient agreement was called into question with these documents. The memo was entitled “Can Certified ESRD Facilities Furnish Acute Dialysis to Hospital Outpatients?” While intended to clarify payment policy, this memo created additional confusion. This memo prohibits Medicare payment for services provided to a patient with AKI by an ESRD-certified outpatient hemodialysis facility. For Medicare to pay for outpatient hemodialysis for a patient with AKI under the Hospital Outpatient Prospective Payment System (OPPS), treatments must be performed in a hospital setting. Hospital AKI billing cannot be done using the same forms and codes as hospital-based outpatient ESRD billing.

What Do ESRD Providers and Nephrology Nurses Need to Know?

Administrative/Operations Issues

• The ESRD provider, whether located in a hospital setting or a free-standing facility, must recognize that CMS will not pay for patients with AKI to dialyze in the ESRD facility. The administrator of the outpatient facility must clarify whether the patient is ESRD eligible prior to the patient’s admission.

• A patient with AKI is not eligible to have a CMS form 2728 completed. The determination as to whether the CMS form 2728 is completed and signed is based on the nephrologist’s certification that the patient has ESRD.

• Patients with AKI are not entered into the CROWNWeb data system.

• If the patient with AKI has commercial insurance, the patient could possibly receive services in an ESRD outpatient facility, since charges for his/her treatment would not be billed to Medicare. The CMS memo provides guidance for Medicare reimbursement, not commercial payors.
Medicaid-only payment sources may cover outpatient hemodialysis for patients with AKI who are treated in an ESRD outpatient facility, but this coverage varies from state to state. Clarify whether Medicaid will pay ESRD outpatient facilities for hemodialysis treatment of patients with AKI in your state.

If the patient with AKI has dual coverage (i.e., Medicare and Medicaid), Medicare is the primary insurance, and outpatient hemodialysis for a patient with AKI in an ESRD facility is not covered.

Patient choice of location to dialyze may be limited to those locations where there is a payor source.

Some hospitals are continuing to contract with ESRD facilities to provide hemodialysis for patients with AKI using non-ESRD related codes. These arrangements generally require preapproval through the ESRD facility’s legal department. Upon admission to the ESRD facility, the patient is identified as a patient with AKI with 30 to 45 days to evaluate recovery of kidney function. Recognize that the hospital cannot bill Medicare for these treatments.

**Clinical Issues**

The patient with AKI who is dialyzed in the ESRD outpatient facility will need close monitoring. The outpatient facility will need to develop policies and procedures specific to the care of patients with AKI.

Considerations for the care of the patient with AKI in an outpatient hemodialysis setting include:

- Assign a nurse responsible to monitor the patient’s progress and response to care and to communicate with the nephrologist.
- The frequency of monitoring a basic metabolic panel (BMP) and urine output to evaluate kidney function and determine the ongoing hemodialysis treatment plan is determined by the nephrologist.
- Fluid management is critical and should be evaluated every treatment to determine current status and the potential need for lower ultrafiltration rates and/or fluid replacement.
- Establish protocols for management of the patient's clinical outcomes (anemia, kinetics, vaccinations) and determine how to include the patient in the quality assurance/performance improvement oversight of care. While the care of the patient with AKI would not be expected to meet the requirements of the ESRD regulations, a patient assessment and plan of care should be completed in order to monitor the patient for recovery or progression to ESRD.

**Medicare Billing Process**

Medicare billing is executed through a network composed of 10 regional contractors called Medicare Administrative Contractors (MAC). Each of these MACs:

- Process Medicare claims.
- Enroll healthcare providers in the Medicare program.
- Educate providers on Medicare billing requirements.
- Handle claims appeals and answer beneficiary and provider inquiries.

Information on your local MAC can be found at http://www.cms.gov/medicare-coverage-database/indexes/contacts-part-b-medicare-administrative-contractor-index.aspx?bc=AgAAAAAAA& (CMS, n.d.). We encourage you to write to the medical directors of your local MAC to advocate for resolution of the multiple problems in management of patients with AKI.

**References**


**Resources**

