INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Renal Dialysis Services

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Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: September 27, 2016	Semiannual update: • Added a note box for managed care contact information • Reorganized information in the *Composite Rate for Dialysis* section • Specified "fee-for-service" claims in the *Billing Guidelines for Renal Dialysis* section • Clarified and streamlined information in the *Dialysis Sessions* section and updated the list of applicable revenue codes • Added reference to modifier in the billing instructions in the *Laboratory Services* section • Updated descriptions of revenue codes in the *Administration of Epoetin* section, and removed an end-dated procedure code	FSSA and HPE
1.2	Policies and procedures as of April 1, 2016 (*Core*MMIS updates as of February 13, 2017) Published: May 23, 2017	*Core*MMIS update: • Updated billing instructions throughout the module to include the Provider Healthcare Portal • Updated the *Composite Rate for Dialysis* section: – Added information about specific services included in the composite rate – Added information about related EOBs – Added subheadings • Specified in the *Diagnosis Codes* section that the renal dialysis diagnosis must be in the principal position	FSSA and HPE

Version	Date	Reason for Revisions	Completed By
		• Updated the *Dialysis Sessions* section as follows: – Separated the four dialysis session revenue codes that are not composite-rate codes from the composite-rate codes – Added composite-rate code 829 – Added EOBs related to composite-rate billing – Updated text to reflect that span dates are no longer allowed for composite-rate dialysis revenue codes • Updated the *Drugs Requiring Detailed Coding* section and added a reference to the table of procedure codes linked to revenue code 636 • Updated the billing instructions and two provider module references in the *Supplies* section • Updated the *Laboratory Services* section as follows: – Added information about the AY modifier – Added information regarding the requirement for medical documentation	

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Note:	*For policy information regarding coverage of renal dialysis services, see the Medical Policy Manual at indianamedicaid.com.*

Introduction

Patients who have end-stage renal disease (ESRD), a chronic condition with kidney impairment considered irreversible and permanent, require a regular course of dialysis or a kidney transplant to maintain life. The Indiana Health Coverage Programs (IHCP) reimburses for routine dialysis. The cost of dialysis treatments includes overhead costs, personnel services, administrative services (including nursing staff members, social worker, and dietician), equipment and supplies, ESRD-related laboratory tests, certain injectable drugs, and biologicals.

This document addresses IHCP coverage, reimbursement, and billing requirements for hemodialysis and peritoneal dialysis services rendered in a hospital outpatient setting, in independent renal dialysis facilities called ESRD dialysis facilities, or in a patient's home.

For information on billing transportation services for members on renal dialysis, see the *Members on Renal Dialysis or in Nursing Homes* section of the *Transportation Services* module.

Note:	*For Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise members, providers must contact the appropriate managed care entity (MCE) for specific policies and procedures. MCE contact information is included in the IHCP Quick Reference Guide available at indianamedicaid.com.*

Composite Rate for Dialysis

The composite rate for dialysis is the charge for the actual treatment or dialysis session and includes certain drugs, medical supplies, and routine laboratory charges.

The IHCP defines specific services included in the composite rate for dialysis. These services are not reimbursed if billed for the same date of service (DOS) as a dialysis composite-rate revenue code, and the claim will be adjudicated as follows:

- Services included in the composite rate that are reported **on the same claim** for the same DOS that a dialysis composite rate revenue code is billed will deny with EOB 3317 – *The procedure billed on this detail is included in the composite rate revenue code billed for this service. It is not separately reimbursable.*
- Services included in the composite rate that are reported **on a different claim** for the same DOS that a dialysis composite-rate revenue code is billed will deny with EOB 6312 – *ESRD procedure being billed for this DOS as all-inclusive to a Medicaid composite rate service already paid for the same DOS.*
- **Previously paid claims** for services included in the composite rate, when a composite-rate revenue code is subsequently billed for the same DOS, will be recouped and post with EOB 6314 – *Previously paid ESRD procedure not payable on the same date of service as a Medicaid composite rate revenue code.* The current claim paid for the composite-rate revenue code for the same DOS will post with EOB 6313 – *A previously paid ESRD procedure is being recouped as all-inclusive to a Medicaid composite rate revenue code when both rendered on the same date of service.*

Drugs Included in the Composite Rate

The following types of drugs are included in the composite rate for dialysis:

- Antiarrhythmics
- Antihistamines
- Antihypertensives
- Dextrose
- Glucose
- Heparin and heparin analogs
- Mannitol
- Pressor drugs
- Protamine
- Saline

Durable and Disposable Items and Medical Supplies Included in the Composite Rate

The composite rate includes all durable and disposable items and medical supplies necessary for the effective performance of a patient's dialysis. Supplies include, but are not limited to, the following:

- Alcohol wipes
- Connecting tubes
- Dialysate
- Dialysate heaters
- Forceps
- Needles
- Rubber gloves
- Syringes
- Topical anesthetics

The composite rate covers certain parenteral items used in the dialysis procedure; therefore, these items cannot be billed separately.

Routine Laboratory Services Included in the Composite Rate

Routine laboratory charges are included in the fee for hemodialysis or peritoneal dialysis and, as such, are not billed separately. The following laboratory tests are included in the composite rate:

- All hematocrit, hemoglobin, and clotting times furnished incident to dialysis treatments
- Prothrombin time for patients on anticoagulant therapy, serum creatinine, and blood urea nitrogen (BUN)
- Serum calcium, serum bicarbonate, alkaline phosphatase, serum potassium, serum phosphorous, aspartate aminotransferase (AST, formerly SGOT), serum chloride, total protein, lactate dehydrogenase (LDH), complete blood count (CBC), and serum albumin

The IHCP may cover nonroutine lab services when billed separately if medical justification is indicated. See the *Laboratory Services* section of this document for more information.

Note:	*The facility performing the dialysis treatment must bill all laboratory services performed in conjunction with the dialysis treatment. An independent lab cannot bill labs associated with dialysis for dialysis patients separately. These independent labs should be contracted with the dialysis facility to perform the actual tests and cannot bill the IHCP separately for their services.*

Billing Guidelines for Renal Dialysis

The billing guidelines in this section are for hemodialysis and peritoneal dialysis used in the following settings:

- Hospital outpatient
- Independent ESRD dialysis facilities
- Patient's home

Providers of dialysis services must use the institutional claim (*UB-04* claim form, Provider Healthcare Portal institutional claim, or 837I electronic transaction) to submit claims to the IHCP. For fee-for-service claims, providers must bill each date-specific service separately on the institutional claim. For example, if the patient receives 15 dialysis treatments in the month, enter 15 detail lines of revenue code 821 on the claim, and note the specific service date for each line. This requirement applies for all other services provided during the month.
For general billing and claim completion instructions, see the *Claim Submission and Processing* module.

Type-of-Bill Codes

Providers must use the following type-of-bill codes when submitting claims for renal dialysis:

- Freestanding ESRD dialysis facilities – Use type-of-bill code 721.
- Outpatient hospital renal dialysis facilities – Use type-of-bill code 131.
- Inpatient renal dialysis services – Use type-of-bill code 111.

Diagnosis Codes

See *Renal Dialysis Services Codes* on the *Code Sets* page at indianamedicaid.com for a list of International Classification of Diseases (ICD) diagnosis codes providers must use as the principal diagnosis when submitting claims for any renal dialysis service.

Revenue Codes

Providers must use revenue codes on the institutional claim (*UB-04* claim form or electronic equivalent) when billing for renal dialysis.

Dialysis Sessions

Dialysis sessions are reimbursable at an established flat statewide rate. Each of the following composite-rate revenue codes represents a dialysis session:

- 821 – *Hemodialysis/composite or other rate*
- 829 – *Other outpatient hemodialysis*
- 830 – *Peritoneal dialysis – Outpatient or home: General*
- 831 – *Peritoneal dialysis/composite or other rate*
- 841 –*Continuous ambulatory peritoneal dialysis (CAPD)/composite or other rate*
- 851 –*Continuous cycling peritoneal dialysis (CCPD)/composite or other rate*
- 881 – *Ultrafiltration*

Only one of these revenue codes may be billed for any given DOS. Claims reporting more than one dialysis composite-rate revenue code for the same DOS will deny with EOB 6311 – *A Medicaid composite rate service has already been paid for the same DOS.* Revenue code 881 is reimbursable only for DOS on which *no other dialysis services* were provided.

Additionally, providers are limited to one unit of service per DOS for these revenue codes. Claims reporting more than one unit for these revenue codes will be cut back to one unit and will post with EOB 4020 – *Units billed exceed allowable units for this service*.

> *Note: Effective February 13, 2017, span dates are not allowed for revenue codes 821, 829, 830, 831, 841, 851, and 881. Providers are limited to one unit of service per detail line for these codes.*

The following renal dialysis codes are not composite-rate codes and should only be billed if a more specific code is inappropriate:

- 820 – *Hemodialysis – Outpatient or home: General*
- 840 – *CAPD – Outpatient or home: General*
- 849 – *Other outpatient CAPD*
- 850 – *CCPD – Outpatient or home: General*

Administration of Epoetin

Providers must use the following revenue codes with the appropriate Healthcare Common Procedure Coding System (HCPCS) code when billing for the administration of epoetin alfa in a hospital outpatient or ESRD setting:

- 634 – *Erythropoietin (EPO), less than 10,000 units*
- 635 – *Erythropoietin (EPO), 10,000 or more units*

The IHCP currently allows payment for HCPCS codes J0885 or Q4081 for patients with a hematocrit range of less than 20 to 40 and above.

Drugs Requiring Detailed Coding

Revenue code 636 is used with the appropriate procedure code to report charges for drugs and biological products that require specific identification when not included in the composite rate. For a list of procedure codes linked to revenue code 636, see *Revenue Codes Linked to Specific Procedure Codes* on the *Code Sets* page at indianamedicaid.com. Submit revenue code 636, the appropriate procedure code identifying the specific drug injected, and the number of units administered.

Supplies

The composite rate includes all durable and disposable items and medical supplies necessary for the effective performance of a patient's dialysis (see the *Composite Rate for Dialysis* section for examples). However, providers can use revenue code 270 – *Medical/surgical supplies and devices: General*, along with the appropriate procedure code, to bill for uncommon supplies not included in the composite rate.

Providers can bill revenue code 270 with multiple units only when the member has one of the renal diagnoses listed in *Renal Dialysis Services Codes* on the *Code Sets* page at indianamedicaid.com and when the service is directly related to the dialysis service. Reimbursement for revenue code 270 is subject to postpayment review and recoupment.

Note:	*Supplies are not paid if billed in conjunction with treatment room revenue codes. Supply revenue codes are denied if billed without a HCPCS surgical procedure code or if billed in conjunction with treatment room revenue codes 45X, 51X, 52X, 70X, 71X, 72X, or 76X, which are also billed without a HCPCS surgical procedure code. For more information about billing for treatment room services, see the Outpatient Hospital and Ambulatory Surgical Center Services module. For more information about outpatient surgery billing and reimbursement, see the Surgical Services module.*

Laboratory Services

The composite rate for hemodialysis or peritoneal dialysis includes routine laboratory charges (see the *Composite Rate for Dialysis* section); therefore, providers cannot bill separately for these charges. However, the IHCP may cover nonroutine lab services when billed separately, if medical justification is indicated.

Use revenue code category 30X with the appropriate HCPCS code and modifier AY when billing separately for these charges. In addition, medical documentation is to be included with the claim indicating that the service was not routine and was medically necessary. When allowable procedure codes are billed on the same DOS as a dialysis composite-rate revenue code, the claim will suspend with EOB 3318 – *ESRD procedure requires attachment indicating medical necessity*.

Note:	*Modifier AY is not required on Medicare crossover claims.*

Procedure Codes for ESRD-Related Physician Services

For ESRD-related physician services, the IHCP uses the same criteria and coding methodology as Medicare. To bill for the management of ESRD dialysis services, providers use procedure codes 90951–90970 on the professional claim (*CMS-1500* claim form, Provider Healthcare Portal professional claim, or 837P electronic transaction). For descriptions of these codes, see *Renal Dialysis Services Codes* on the *Code Sets* page at indianamedicaid.com.