INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Renal Dialysis Services

LIBRARY REFERENCE NUMBER: PROMOD00045
PUBLISHED: NOVEMBER 16, 2017
POLICIES AND PROCEDURES AS OF SEPTMBER 1, 2017
VERSION: 2.0

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	Scheduled update	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	FSSA and HPE
2.0	Policies and procedures as of September 1, 2017 Published: November 16, 2017	Scheduled update: • Added reference to *Member Eligibility and Benefit Coverage* module for ESRD waiver liability • Updated the composite-rate revenue codes in the *Dialysis Sessions* section • Updated the billing guidelines in the *Administration of Epoetin* section • Added description for the AY modifier in the *Laboratory Services* section	FSSA and DXC

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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. For information about IHCP coverage with a liability for ESRD patients who do not meet Medicaid income requirements, see the *Member Eligibility and Benefit Coverage* 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 explanation of benefits (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 module 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, IHCP Provider Healthcare Portal [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:

- 820 – *Hemodialysis – Outpatient or home: General**
- 821 – *Hemodialysis/composite or other rate*
- 823 – *Hemodialysis – Outpatient or home: Home equipment*
- 825 – *Hemodialysis – Outpatient or home: Support services*
- 829 – *Other outpatient hemodialysis*
- 830 – *Peritoneal dialysis – Outpatient or home: General*
- 831 – *Peritoneal dialysis/composite or other rate*
- 840 – *Continuous ambulatory peritoneal dialysis (CAPD) – Outpatient or home: General**
- 841 – *CAPD/composite or other rate*
- 842 – *CAPD – Outpatient or home: Home supplies*
- 844 – *CAPD – Outpatient or home: Maintenance 100%*
- 845 – *CAPD – Outpatient or home: Support services*
- 849 – *Other outpatient CAPD**
- 850 – *Continuous cycling peritoneal dialysis (CCPD) – Outpatient or home: General**
- 851 – *CCPD/composite or other rate*
- 855 – *CCPD – Outpatient or home: Support services*
- 881 – *Ultrafiltration*

Renal dialysis codes in this list that are marked with an asterisk (*) should be billed only if a more specific code is inappropriate.

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 composite-rate revenue codes. Providers are limited to one unit of service per detail line for these codes.*

Administration of Epoetin

Providers must follow National Billing guidelines to determine which revenue codes are appropriate to bill with the proper Healthcare Common Procedure Coding System (HCPCS) codes when billing for the administration of epoetin in a hospital outpatient or ESRD setting.

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.

When billing separately for these charges, use revenue code category 30X with the appropriate HCPCS code and modifier AY – *Item or service furnished to an end-stage renal disease (ESRD) patient that is not for the treatment of ESRD*. 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, 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.