



P R O V I D E R   B U L L E T I N

B T 2 0 0 2 2 3

M A Y 2 9 , 2 0 0 2

**To: All Acute Care Hospitals and End-Stage Renal Disease Clinics**

**Subject: Billing and Claim Completion Guidelines for Renal Dialysis Services**

*Note: For providers rendering services to members enrolled in the risk based managed care (RBMC) delivery system, please contact the appropriate Managed Care Organization (MCO) regarding billing and reimbursement information.*

**Overview**

This bulletin provides acute care hospitals and End Stage Renal Disease (ESRD) clinics with a comprehensive overview of the billing and UB-92 claim completion guidelines established by the Office of Medicaid Policy and Planning (OMPP). In 1997 it was discovered that some portions of dialysis services were not processing through the IndianaAIM system in what might be the easiest and least complicated format. This specifically applied to *Revenue Code 821 – Composite Rate* and *Revenue Codes 634, 635, and 636 – Drugs utilized in the dialysis session*. Extensive research was completed, resulting in the billing guidelines outlined in this bulletin. Please note that Banner Page BR200101, published in January 2001, contained an article outlining the appropriate claim submission guidelines for Medicare crossover claims with spenddown *Form 8A* attached. These claims should no longer be mailed to the attention of the provider field consultant, but should be mailed to the EDS UB-92 Crossover/Outpatient Claim address below:

**EDS UB-92 Crossover/Outpatient Claims  
P.O. Box 7271  
Indianapolis, IN 46207-7271**

## Stand-Alone Renal Dialysis Services

This section addresses billing requirements for hemodialysis and peritoneal dialysis services rendered in a hospital outpatient setting, independent renal dialysis facilities (ESRD dialysis facilities), or a patient's home.

Routine dialysis is provided to patients who have ESRD, a chronic condition with kidney impairment considered irreversible and permanent. Patients with ESRD require a regular course of dialysis or a kidney transplant to maintain life. The cost of dialysis treatments includes overhead costs, personnel services, administrative services (includes nursing staff members, social worker, and dietician), equipment and supplies, ESRD related laboratory tests, certain injectable drugs, and biologicals.

## Composite Rate

The composite rate for dialysis is the charge for the actual treatment or dialysis session. Routine laboratory charges are included in the fee for hemodialysis or peritoneal dialysis and, as such, are not billed separately. However, nonroutine lab services are covered when billed separately if medical justification is indicated. The composite rate also 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:

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

The composite rate covers certain parenteral items used in the dialysis procedure and cannot be billed separately. The following drugs are included under the composite rate:

- Heparin
- Protamine
- Mannitol
- Saline

- Pressor drugs
- Glucose
- Dextrose
- Antihistamines
- Antiarrhythmics
- Antihypertensives

## Billing Guidelines

The billing guidelines listed below are for hemodialysis and peritoneal dialysis and are used in the following settings:

- Hospital outpatient
- Independent renal dialysis facilities (ESRD dialysis facilities)
- Patient's home

Providers of dialysis services must use the *UB-92* claim to submit claims to the IHCP. In 1997, the IHCP began allowing providers to bill for the drugs associated with renal dialysis services on the *HCFA-1500* claim form. **All** services provided by the ESRD facility **must** be billed on the *UB-92* claim form. For IHCP only claims, providers must bill each date specific service separately on the *UB-92* claim form. For example, if the patient receives 15 dialysis treatments in the month, then enter 15 detail lines of *Revenue Code 821* on the *UB-92* with the specific service date in *field locator 45*. This is true for all other services provided during the month.

Providers may want to consider submitting two claims per month for those IHCP members who are **not** dually eligible (Medicare and IHCP) since the amount of services rendered during the month can result in a continuation claim greater than two pages or 46 detail lines. The IndianaAIM system cannot accept claims exceeding that length. Remember when submitting a continuation claim, *detail line 23* on page one must indicate *page 1 of 2* while *detail line 23* of page two reflects the *Revenue Code 001 - Total Charges*. Providers are to enter the words *continuation bill in form locator 37* of each subsequent *UB-92* claim form ... for example, *1 of 2, 2 of 2*, indicating it is a continued bill. It is also important to remember that page two of a continuation claim must be turned end to end under page one so that the second page is not mistaken for a new claim but is recognized as the continuation of page one. Only professional (physician) services are billable on the *HCFA-1500* claim form.

## UB-92 Completion Guidelines

### **Type of Bill Codes**

Providers must use the following *Type of Bill* codes when submitting claims for renal dialysis:

- Free standing renal dialysis facilities should use *Type of Bill code 721*
- Outpatient hospital renal dialysis facilities should use *Type of Bill code 131*
- Inpatient renal dialysis services should be billed with *Type of Bill code 111*

### **Diagnosis Codes**

- 585 – Chronic renal failure
- 586 – Renal failure unspecified

### **Revenue Codes**

- **Dialysis Sessions** – Hemodialysis sessions are reimbursable at an established flat statewide rate. These services represent the number of hemodialysis sessions for outpatient or home and their units of service reflect the number of actual sessions rendered (*one per day*). Use *Revenue Codes 82X, 83X, 84X, and 85X with the appropriate HCPCS code*.
  - **Revenue category 82X:** 821 – hemodialysis/composite or other rate. This revenue code represents the number of hemodialysis sessions, outpatient or home, rendered, per day. Providers should indicate a one in *field 46, Service Units*, on the *UB-92* claim form. Only one unit per date of service is allowed. HCPCS codes may be required for *Revenue Code category 82X* if the provider is billing for outpatient renal dialysis. For ESRD providers, *Revenue Code category 82X* cannot be billed on the same claim with 83X, 84X and 85X.
  - **Revenue category 83X:** 83X – peritoneal dialysis/composite or other rate. This revenue code represents the number of peritoneal dialysis sessions performed in the outpatient or home setting. Providers should indicate a one in *field 46, Service Units*, on the *UB-92* claim form. Only one unit per date of service is allowed. HCPCS codes are required when billing for *Type of Bill 72X, Clinic – Hospital Based or Independent Renal Dialysis Center*.
  - **Revenue category 84X:** 841 – CAPD/composite or other rate. This revenue code represents the charges for continuous ambulatory peritoneal dialysis, using the patient's peritoneal membrane as a dialyzer, which is performed in the home or outpatient setting. Providers should indicate a one in *field 46 – Service Units field* on the *UB-92* claim form. Only one unit per date of service is allowed. For ESRD providers, *Revenue Code category 82X* cannot be billed on the same claim with 83X, 84X and 85X.

- **Revenue category 85X:** 85X – CCPD/composite or other rate. This revenue code represents the charges for continuous cycling peritoneal dialysis performed in an outpatient or home setting. Providers should indicate a one in *field 46 – Service Units field* on the *UB-92* claim form. Only one unit per date of service is allowed. HCPCS codes are required when billing for *Type of Bill 72X – Clinic – Hospital Based or Independent Renal Dialysis Center*.
- **Administration of Epoetin** – Providers must use the following revenue codes with the appropriate HCPCS (*Q*) code when billing for the administration of Epoetin in a hospital outpatient or ESRD setting. *The IHCP currently allows payment for HCPCS codes Q9920 through Q9940 for patients with a hematocrit range of less than 20 to 40 and above.*
  - 634 Epoetin less than 10,000 units
  - 635 Epoetin, 10,000 or more units
- **Drugs Requiring Detailed Coding** – *Revenue Code 636* is used with the appropriate HCPCS code to report charges for drugs and biological products requiring specific identification. *Revenue Code 636* should be submitted in *field 42* on the *UB-92* claim form. The appropriate HCPCS code, *including J codes*, identifying the specific drug injected, must be submitted in *field 44*. The number of units administered must be submitted in *field 46* on the *UB-92* claim form.
- **Laboratory Services** – Routine laboratory charges are included in the composite rate for hemodialysis or peritoneal dialysis and, as such, cannot be billed separately. However, non-routine lab services are covered when billed separately if medical justification is indicated. Use *Revenue Code category 30X* with the appropriate HCPCS code. Laboratory tests included in the composite rate and their anticipated frequency include the following:
  - Per Treatment – all hematocrit, hemoglobin and clotting times furnished incident to dialysis treatments
  - Weekly – prothrombin time for patients on anticoagulant therapy, serum creatinine, and blood urea nitrogen (BUN)
  - Monthly – 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

*Note: All laboratory services performed must be billed by the facility performing the dialysis treatment. An independent lab cannot bill labs 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.*

- **Supplies** – The composite rate includes all durable and disposable items and medical supplies necessary for the effective performance of a patient's dialysis as noted previously in this bulletin. However, providers can use *Revenue Code 270*

for billing supplies outside the list of those included in the composite rate. 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, and 76X*, also billed without a HCPCS surgical procedure code.

## UB-92 Crossover Claim Considerations

Crossover claims that electronically cross from Medicare to the IHCP are considered for payment of the deductible and coinsurance amounts. Providers should reference the *IHCP Provider Bulletin BT200101* dated January 12, 2001, for information about the new *Medical and Institutional Crossover Claim Forms* for use when claims do not automatically transfer from Medicare to the IHCP. However, providers whose Medicare claims do not auto-cross and who submit Medicare claims to AdminaStar of Indiana should contact the EDS Customer Assistance Unit at (317) 655-3240 or 1-800-577-1278 to verify that the correct Medicare number has been recorded in the provider's IHCP enrollment file. Providers who submit claims to a Medicare intermediary other than AdminaStar of Indiana can contact the Customer Assistance Unit, at the numbers above, to report the intermediary name and contact name, if available, the telephone number, and address. EDS is attempting to increase the number of Medicare intermediaries contracted with the IHCP for the electronic transfer of Medicare payment data.

## Summary

Direct questions about the information in this bulletin to the EDS Customer Assistance Unit at (317) 655-3240 or 1-800-577-1278.

*CDT-3/2000 (including procedure codes, definitions (descriptions) and other data) is copyrighted by the American Dental Association. © 1999 American Dental Association. All rights reserved. Applicable Federal Acquisition Regulation System/Department of Defense Acquisition Regulation System (FARS/DFARS) Apply.*

*CPT codes, descriptions and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Apply.*