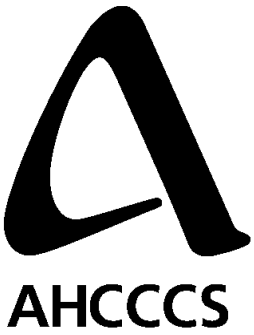
Chapter 15

Dialysis Services



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NOTE: The covered services, limitations, and exclusions described in this chapter are global in nature and are listed here to offer general guidance to providers. Specific questions regarding covered services, limitations, and exclusions can be found in the AHCCCS Medical Policy Manual (AMPM) and the Arizona Administrative Codes (A.A.C.) R9-22-201 et. seq.

Please direct questions to the AHCCCS Office of Medical Policy, Analytics and Coding (OMPAC) at (602) 417-4066. The AHCCCS Medical Policy Manual (AMPM) also is available on the AHCCCS web site at www.azahcccs.gov.

A. COVERED SERVICES

AHCCCS covers dialysis services provided by Medicare-certified hospitals and Medicare-certified End Stage Renal Disease (ESRD) providers registered with AHCCCS.

Covered services include:

1. All supplies, diagnostic testing (including routine medically necessary laboratory tests) and drugs medically necessary for the dialysis treatment.
2. Medically necessary outpatient dialysis treatments.
3. Self-dialysis training provided by free-standing dialysis facilities.
4. Inpatient dialysis treatments only when the hospitalization is for:
   a. An acute medical condition requiring hemodialysis treatments, or
   b. An AHCCCS-covered medical condition experienced by a recipient routinely maintained on an outpatient chronic dialysis program, or
   c. Placement, replacement, or repair of the chronic dialysis route (shunt or cannula).

The following services are *not* covered:

1. Hospital admissions solely for chronic dialysis
2. Blood, including storage and processing independent of the dialysis service
3. Method II services

B. FEDERAL EMERGENCY SERVICES (FES) RECIPIENTS

Arizona Revised Statutes §36-2903.03 provides that certain non-citizens who otherwise meet the requirements for Title XIX eligibility are entitled to receive only emergency services as defined in the AMPM Chapter 1100. AHCCCS will reimburse providers for emergency outpatient dialysis services provided to Federal Emergency Services (FES) members with End Stage Renal Disease (ESRD).

Outpatient dialysis services are covered as an emergency service when the recipient's physician, nurse practitioner or physician assistant signs a monthly certification stating that member requires dialysis services at least three times a week. The monthly certification, which will be audited by the AHCCCS Administration, must be maintained by the provider in the patient's medical records. This required form is called a "Monthly Certification of Emergency Medical Condition" and can be found in the AMPM Chapter 1100, Section 1120, Exhibit 1120-2.

When dialysis services are needed for the first time, the provider must submit an "Initial Dialysis Case Creation" form to the AHCCCS Administration's Utilization Management/Care Management (UM/CM) Department. This form can be found in the AMPM Chapter 1100, Section 1120, Exhibit 1120-1.

Inpatient dialysis services for FESP recipients are subject to the same criteria of a current "emergency medical or behavior health condition" as defined in AMPM Chapter 1100 Federal Emergency Services Program Overview.

C. AUTHORIZATION REQUIREMENTS

Prior authorization is not required for monthly dialysis supervision or services provided to AHCCCS fee-for-service recipients. However, providers must notify the AHCCCS Utilization Management/Care Management (UM/CM) Department when beginning treatment for Federal Emergency Services Program (FESP) recipients who are eligible to receive dialysis services. (See explanation above)

D. BILLING FOR DIALYSIS SERVICES

Physicians who bill for ESRD services must specify the units of service as defined by the procedure code in order to be reimbursed correctly.

For example, if the procedure code billed by the physician states that the services are for one month only one unit should be billed. If the physician bills for 30 units for these procedures for dates of service September 1-30, the claim could be denied.

Physician charges for EKG or radiology services must be billed by the physician.

Hospital-based or free standing renal dialysis centers must bill on the UB-04 claim form and use bill type 72X and the appropriate condition codes.

Hospitals with Medicare-certified outpatient dialysis facilities must split claims between dialysis services and other outpatient services.

Free standing renal dialysis facilities must bill all of the charges for one month on one UB-04 claim form. Split billing these dates of service is not allowed and the claims will be denied.

Free-standing dialysis facilities are reimbursed a composite rate, and services included in the composite rate may not be billed separately unless they are provided more frequently than specified by policy. AHCCCS follows Medicare policy with respect to the services included in the composite rate.

The following is the list of drugs that are included in the composite rate and may *not* be billed separately:

1. Heparin and heparin antidotes
2. Mannitol
3. Glucose
4. Antiarrythmics
5. Saline
6. Antihypertensives
7. Protamine
8. Pressor drugs
9. Antihistamines
10. Local anesthetics
11. Dextrose
12. Antibiotics (if used to treat peritonitis associated with peritoneal dialysis)
13. Albumin (if used as a volume expander)

Separately billable drugs and vaccines require medical documentation. Separately billable drugs dispensed outside the dialysis facility must be billed by the dispensing pharmacy. (See Chapter 12, Pharmacy Services)

A free-standing ESRD facility must have appropriate CLIA certification to bill for clinical laboratory services. Laboratory services included in the composite rate that are performed by a separate laboratory are the responsibility of the dialysis facility.

Laboratory services that may ***not*** be billed separately because they are included in the composite rate for hemodialysis and CCPD patients include:

1. All routine clinical chemistry tests

2. The following if performed *per treatment or less frequently*:
   a. Hematocrit or hemoglobin and clotting time tests furnished incident to dialysis treatments

3. The following if performed *once a week or less frequently*:
   a. Prothrombin time for patients on anticoagulant therapy
   b. Serum creatinine
   c. BUN

4. The following if performed *once a month or less frequently*:
   a. Serum calcium
   b. Serum chloride
   c. Total protein
   d. CBC
   e. Serum bicarbonate
   f. Serum phosphorous
   g. Total potassium
   h. Serum albumin
   i. Alkaline phosphatase
   j. SGOT
   k. LDH

CAPD tests that may *not* be billed separately because they are included in the composite rate for CAPD patients if performed *once a month or less frequently* include:

1. BUN
2. Creatinine
3. Sodium
4. Carbon Dioxide
5. Calcium
6. Magnesium
7. Alkaline Phosphatase
8. Inorganic Phosphate
9. Potassium
10. SGOT
11. LDH
12. Total Protein
13. Albumin
14. Hematocrit
15. Hemoglobin
16. Dialysate Protein (Serum Protein)

If any of these tests are performed more frequently than specified, the additional tests may be billed separately. These tests may be covered by AHCCCS only if medically justified by supporting documentation.

Free-standing and hospital-based dialysis facilities must bill for the Erythropoietin (EPO) on the UB-04 claim form with revenue code 634 (less than 10,000 units administered per dialysis treatment) or 635 (10,000 units or more). If the total units of EPO administered is more than 100,000, documentation of medical necessity is required. Providers must enter the total units administered in Field 39, 40, or 41 using value code 68 and the number of times EPO is administered in Field 46.

For Method I patients self-dialyzing at home, EPO may be ordered for one or two months. Revenue code 635 should be billed. Providers should enter condition code 70 in any condition code field (Fields 24-30). Value code 68 and the total units of EPO ordered should be entered in Field 39, 40, or 41. Because the facility's staff did not administer EPO, the units field (Field 46) is zero. No special documentation for revenue code 635 is required in this case.

Dialysis facilities must enter the appropriate HCPCS code for EPO injections when billing revenue codes 634 and 635. Providers must enter the appropriate HCPCS code in the HCPCS/Rates field (Field 44) on the UB-04 paper claim form. If a HCPCS code is not billed with revenue code 634 or 635, the line will be denied.

Providers must enter hematocrit test results in Field 39, 40, or 41 using value code 49. EPO will not be reimbursed if the hematocrit results are greater than 37.4 per cent unless medically justified. If the recipient resides at an elevation above 6,000 feet, a hematocrit of up to 39.5 per cent is allowed. Documentation specifying the elevation is required.

To bill for self-dialysis training, free-standing dialysis facilities approved to provide self-dialysis training must enter condition code 73 in any condition code field (Fields 24-30) of the UB-04 claim form. Facilities must bill revenue code 841 (Continuous ambulatory peritoneal dialysis, per day) or revenue code 851 (Continuous cycling peritoneal dialysis, per day). If revenue code 841 or 851 is billed without condition code 73, claims will be reimbursed the per diem for free-standing dialysis facilities.

Providers must not bill for self-dialysis training on the same claim form used to bill for other dialysis services. Billing for self-dialysis training on a separate claim form ensures that the AHCCCS claims processing system accurately distinguishes between claims for dialysis services and claims for self-dialysis training. The claim for self-dialysis training will be assigned a separate AHCCCS Claim Reference Number (CRN) from the claim for other dialysis services for the same recipient and date of service span.

AHCCCS requires that certain services provided by ESRD facilities and hospitals be billed with a CPT or HCPCS code that further defines the services described by the revenue code listed on the UB-04 claim form. Units must be consistent with CPT/HCPCS code definitions.

The following table summarizes revenue code – CPT/HCPCS code requirements for ESRD facilities.

BILLING CPT/HCPCS CODES WITH REVENUE CODES

UB-92 REVENUE – CPT/HCPCS REQUIREMENTS FOR ESRD FACILITIES	
REVENUE CODE	**HCPCS/CPT CODES**
270 – Med-Sur Supplies & Drug Admin	Various
304 – Lab/NR Dialysis	83036, 85041
320 – Dx X-Ray	78350
380 – Blood	P9022
381 – Blood/Pkd Red	P9021
382 – Blood/Whole	P9010
383 – Blood/Plasma	P9017
384 – Blood/Platelets	P9019, P9020
385 – Blood/Leukocytes	P9016
387 – Blood/Derivatives	P9012
390 – Blood/Stor-Processing	86000 – 86999
634/635 – Drug/EPO	Enter the appropriate HCPCS code
636 – Drugs/Detail Coding	Enter the appropriate HCPCS/CPT code for injections and vaccines administered.
730 – EKG/ECG	93000, 93005
771 – Vaccine Administration	G0008, G0009, G0010, 90471, 90472
821 – Hemo/Composite	90935, 90937, 90999
841 – CAPD/Composite	90999
851 – CCPD Composite	90999
921 – Perivascular Lab	93990
922 – EMG	95900, 95904

E. DIALYSIS CLAIMS WITH MEDICARE COVERAGE

If the recipient has Medicare coverage, the provider must bill AHCCCS for the actual cost of the treatment. The Medicare EOMB must be attached to the claim.

AHCCCS reimburses the Medicare deductible and coinsurance amounts. To be reimbursed properly, providers must report the Medicare coinsurance and deductible amounts in the Value Code fields on the UB-04 claim form. Claims with zeroes in both the coinsurance and deductible field may be denied. (refer to Chapter 9 Medicare)

Providers should report the Medicare Part B Deductible, if applicable, by entering Value Code B1 and the amount in Field 39B. Medicare Part B Coinsurance is reported by entering Value Code B2 and the amount in Field 40B.

	39 VALUE CODES			40 VALUE CODES			41 VALUE CODES		
	CODE	AMOUNT		CODE	AMOUNT		CODE	AMOUNT	
a									
b	B1	100	00	B2	125	00			
c									
d									

Value Code B1 = Medicare Part B Deductible
Value Code B2 = Medicare Part B Coinsurance

F. REIMBURSEMENT

AHCCCS reimburses free-standing dialysis facilities under an all inclusive composite rate which covers non-physician services, supplies, diagnostic testing, and drugs. Rates include separate composite rates for metropolitan Phoenix, metropolitan Tucson, and all other areas.

Composite rates have been established for the following revenue codes for services provided by free-standing dialysis facilities:

821	Hemodialysis (per treatment)
841	Continuous Ambulatory Peritoneal Dialysis (per day)
851	Continuous Cycling Peritoneal Dialysis (per day)

Providers who bill for self-dialysis training services are reimbursed the training composite rate for claims billed with revenue codes 841 or 851 and condition code 73.

All other separately billable dialysis services will be reimbursed at FFS rate for covered services.

For hospital-based dialysis facility reimbursement, see Chapter 11, Hospital Services.

G. MEDICAL REVIEW

Fee-for-service dialysis claims submitted to the AHCCCS Administration are subject to medical review.

Free-standing dialysis facilities are reimbursed a composite rate, and services included in the composite rate may not be billed separately unless they are provided more frequently than specified by policy. AHCCCS follows Medicare policy with respect to the services included in the composite rate.

Services that are billed separately because they were provided more frequently than specified by policy must be justified by supporting documentation. The AHCCCS Claims Medical Review Unit will review dialysis claims to determine if separate charges for services included in the composite rate are supported by the documentation.

If no documentation is submitted with the claim or if the documentation does not support the charges, those services will be disallowed.

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