Renal Dialysis Services
**Revision History**

<table>
<thead>
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<th>Version</th>
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<tr>
<td>1.0</td>
<td>Policies and procedures as of October 1, 2015 Published: February 25, 2016</td>
<td>New document</td>
<td>FSSA and HPE</td>
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<tr>
<td>1.1</td>
<td>Policies and procedures as of April 1, 2016 Published: September 27, 2016</td>
<td>Scheduled update</td>
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<td>1.2</td>
<td>Policies and procedures as of April 1, 2016 <em>(CoreMMIS updates as of February 13, 2017)</em> Published: May 23, 2017</td>
<td>CoreMMIS update</td>
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<tr>
<td>2.0</td>
<td>Policies and procedures as of September 1, 2017 Published: November 16, 2017</td>
<td>Scheduled update</td>
<td>FSSA and DXC</td>
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<tr>
<td>2.1</td>
<td>Policies and procedures as of September 1, 2017 Published: January 23, 2018</td>
<td>Corrected the hematocrit range in the Administration of Epoetin section</td>
<td>FSSA and DXC</td>
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| 3.0     | Policies and procedures as of September 1, 2018 Published: January 29, 2019 | Scheduled update:  
- Edited and reorganized text as need for clarity  
- Updated the note box at the beginning with the new standard wording  
- Updated links to the new IHCP website  
- Added a code table reference in the Composite Rate for Dialysis section and removed the following subsections:  
  - Drugs Included in the Composite Rate  
  - Durable and Disposable Items and Medical Supplies Included in the Composite Rate  
  - Routine Laboratory Services Included in the Composite Rate  
- Added the Drugs and Biologics heading and introductory text for two related subsections | FSSA and DXC |
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|         |      | • Updated the *Administration of Epoetin* section with new requirements  
• Removed specific procedure codes from the *Billing for Physician Services Related to Renal Dialysis* section |              |
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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.

This module addresses IHCP coverage, reimbursement, and billing requirements for hemodialysis and peritoneal dialysis services rendered in the following settings:

- Hospital outpatient
- Independent renal dialysis facilities (called ESRD dialysis facilities)
- 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.

Composite Rate for Dialysis

Dialysis sessions are reimbursed at a composite rate that includes overhead costs, personnel services, administrative services (including nursing staff members, social worker, and dietician), equipment and supplies, ESRD-related laboratory tests, and certain injectable drugs and biologicals.

The IHCP defines specific services included in the composite rate for dialysis. See the Procedure Codes Included in the Renal Dialysis Composite Rate table in Renal Dialysis Services Codes (accessible from the Code Sets page at in.gov/medicaid/providers). These services are not reimbursed if billed for the same date of service 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 date of service 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.

- Services included in the composite rate that are reported on a different claim for the same date of service 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 date of service.
• **Previously paid claims** for services included in the composite rate, when a composite-rate revenue code is subsequently billed for the same date of service, 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 date of service will post with EOB 6314 – *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.*

**Billing for Renal Dialysis**

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.

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

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

For a list of International Classification of Diseases (ICD) diagnosis codes that providers must use as the principal diagnosis when submitting claims for any renal dialysis service, see Renal Dialysis Services Codes (accessible from the Code Sets page at in.gov/medicaid/providers).

Providers must bill each date-specific service separately on the 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.

**Dialysis Sessions**

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

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 date of service. Claims reporting more than one dialysis composite-rate revenue code for the same date of service will deny with EOB 6311 – A Medicaid composite rate service has already been paid for the same date of service. Revenue code 881 is reimbursable only for dates of service on which no other dialysis services were provided.

Additionally, providers are limited to one unit of service per date of service 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:** Span dates are not allowed for composite-rate revenue codes. Providers are limited to one unit of service per detail line for these codes.

**Equipment and 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). 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 (accessible from the Code Sets page at in.gov/medicaid/providers) 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 Facility 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 – Laboratory 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 date of service as a dialysis composite-rate revenue code, the claim will suspend with EOB 3318 – ESRD procedure requires attachment indicating medical necessity.
The facility performing the dialysis treatment must bill all laboratory services performed in conjunction with the dialysis treatment. An independent lab cannot bill laboratory services associated with dialysis 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.

**Drugs and Biologicals**

The dialysis composite rate includes certain injectable drugs and biologicals (see the Composite Rate for Dialysis section), and providers cannot bill separately for these charges.

**Drugs Requiring Detailed Coding**

Revenue code 636 – Drugs requiring detailed coding 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, accessible from the Code Sets page at in.gov/medicaid/providers. Submit revenue code 636, the appropriate procedure code identifying the specific drug injected, and the number of units administered.

**Administration of Epoetin**

For dates of service on or after March 1, 2018, the IHCP covers the administration of epoetin in the hospital outpatient or ESRD treatment setting for members with a hemoglobin level of less than 13. The IHCP allows payment for the following Healthcare Common Procedure Coding System (HCPCS) codes for the treatment of ESRD:

- J0882 – Injection, darbepoetin alfa, 1 mcg
- J0887 – Injection, epoetin beta, 1 microgram
- Q4081 – Injection, epoetin alfa, 100 units
- Q5105¹ – Injection, epoetin alfa, biosimilar, (Retacrit) (for ESRD on dialysis), 100 units

Note: For dates of service prior to March 1, 2018, the IHCP allowed payment for HCPCS codes J0885 and Q4081 for the administration of epoetin for ESRD treatment in patients with a hematocrit level of up to 40.

Providers must follow national billing guidelines to determine which revenue codes are appropriate to use with the applicable HCPCS codes when billing for the administration of epoetin in a hospital outpatient or ESRD treatment setting.

**Billing for Physician Services Related to Renal Dialysis**

For ESRD-related physician services, the IHCP uses the same criteria and coding methodology as Medicare. To bill for the management of renal dialysis services, providers use the appropriate procedure codes on the professional claim (CMS-1500 claim form, Portal professional claim, or 837P electronic transaction).

¹ Q5105 became covered effective July 1, 2018.