INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Renal Dialysis Services

LIBRARY REFERENCE NUMBER: PROMOD00045
PUBLISHED: JAN. 25, 2024
POLICIES AND PROCEDURES AS OF OCT. 1, 2023
VERSION: 7.0

Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of Oct. 1, 2015 Published: Feb. 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: Sept. 27, 2016	Scheduled update	FSSA and HPE
1.2	Policies and procedures as of April 1, 2016 (*Core*MMIS updates as of Feb. 13, 2017) Published: May 23, 2017	*Core*MMIS update	FSSA and HPE
2.0	Policies and procedures as of Sept. 1, 2017 Published: Nov. 16, 2017	Scheduled update	FSSA and DXC
2.1	Policies and procedures as of Sept. 1, 2017 Published: Jan. 23, 2018	Correction	FSSA and DXC
3.0	Policies and procedures as of Sept. 1, 2018 Published: Jan. 29, 2019	Scheduled update	FSSA and DXC
4.0	Policies and procedures as of Jan. 1, 2020 Published: Feb. 18, 2020	Scheduled update	FSSA and DXC
5.0	Policies and procedures as of Dec. 1, 2020 Published: Jan. 5, 2021	Scheduled update	FSSA and Gainwell
6.0	Policies and procedures as of March 1, 2022 Published: April 12, 2022	Scheduled update	FSSA and Gainwell
7.0	Policies and procedures as of Oct. 1, 2023 Published: Jan. 25, 2024	Scheduled update: • Edited text as needed for clarity	FSSA and Gainwell

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> *Note: The information in this module applies to Indiana Health Coverage Programs (IHCP) services provided under the **fee-for-service (FFS)** delivery system. For information about services provided through the **managed care** delivery system – including Healthy Indiana Plan (HIP), Hoosier Care Connect or Hoosier Healthwise services – providers must contact the member's managed care entity (MCE) or refer to the MCE provider manual. MCE contact information is included in the IHCP Quick Reference Guide available at in.gov/medicaid/providers.*
>
> *For updates to information in this module, see IHCP Bulletins at in.gov/medicaid/providers.*

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
- Freestanding renal dialysis clinic (also 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 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.*

Billing for Renal Dialysis

Providers of dialysis services must use the institutional claim (*UB-04* claim form, IHCP Provider Healthcare Portal [IHCP 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 renal dialysis clinics – Use type-of-bill code 721.
- Inpatient renal dialysis services – Use type-of-bill code 111.
- Home-based dialysis service – Use the same type-of-bill code normally used by the billing provider.

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 – Outpatient or home – Hemodialysis/composite or other rate*
- 823 – *Hemodialysis – Outpatient or home – Home equipment*
- 825 – *Hemodialysis – Outpatient or home – Support services*
- 829 – *Hemodialysis – Outpatient or home – Other outpatient hemodialysis*
- 830 – *Peritoneal dialysis – Outpatient or home – General*
- 831 – *Peritoneal dialysis – Outpatient or home – Peritoneal/composite or other rate*
- 841 – *Continuous ambulatory peritoneal dialysis (CAPD) – Outpatient or home – CAPD/composite or other rate*
- 851 – *Continuous cycling peritoneal dialysis (CCPD) – Outpatient or home – CCPD/composite or other rate*
- 881 – *Miscellaneous Dialysis – Ultrafiltration*

**Note: Revenue code 820 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 if 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 Healthcare Common Procedure Coding System (HCPCS) surgical procedure code or if billed in conjunction with treatment room revenue codes 45X, 48X, 51X, 52X, 70X, 71X, 72X, and 76X, when 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*.

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

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 With Special Procedure Code Linkages*, 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

The IHCP covers the administration of epoetin in the hospital outpatient or renal dialysis treatment facility setting for members with a hemoglobin level of less than 13. The IHCP allows payment for the following HCPCS codes for the treatment of ESRD:

- J0882 – *Injection, darbepoetin alfa, 1 mcg (for ESRD on dialysis)*
- J0887 – *Injection, epoetin beta, 1 microgram (for ESRD on dialysis)*
- Q4081 – *Injection, epoetin alfa, 100 units (for ESRD on dialysis)*
- Q5105 – *Injection, epoetin alfa, biosimilar, (Retacrit) (for ESRD on dialysis), 100 units*

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 renal dialysis treatment facility 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, IHCP Portal professional claim or 837P electronic transaction).