Revision Dates: 9/12/2019; 4/5/2018; 1/23/2018

General Information

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 Arizona Administrative Codes (A.A.C.) R9-22-201 et. seq. and in the AHCCCS Medical Policy Manual (AMPM), which is available on the AHCCCS website at https://www.azahcccs.gov/shared/MedicalPolicyManual/.

Covered Services

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

For non-Federal Emergency Services Program (FESP) members, no prior authorization is required for dialysis supervision or services.

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; and/or
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 member routinely maintained on an outpatient chronic dialysis program; or
    c. Placement, replacement, or repair of the dialysis access route (shunt, cannula, fistula, or graft).

The following services are *not* covered:

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

Federal Emergency Services (FES) Members

Arizona Revised Statutes §36-2903.03 and 8 USC 1611 provide that certain non-citizens, who otherwise meet the requirements for Title XIX eligibility, are entitled to receive only emergency services as defined in federal law within section 1903(v)(3) of the Social Security Act, 42 CFR 440.255, and in AMPM 1100, Federal Emergency Services Program

Overview. AHCCCS will reimburse providers for emergency outpatient dialysis services provided to Federal Emergency Services Program (FESP) members with End Stage Renal Disease (ESRD).

Outpatient dialysis services are covered as an emergency service when the member's physician, nurse practitioner or physician assistant signs a monthly certification stating that the member requires dialysis services at least three times a week. The monthly certification, which will be audited by the Division of Fee-for-Service Management (DFSM), 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 AMPM 1120, Exhibit 1120-2.

When dialysis services are needed for the first time, the provider must submit an "Initial Dialysis Case Creation" form to DFSM. This form can be found in AMPM 1120, Exhibit 1120-1.

Both forms are also available online at:
https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/priorauthorizationforms.html

Inpatient dialysis services for FESP members are subject to the same criteria of a current "emergency medical or behavior health condition" as defined in AMPM 1100, Federal Emergency Services Program Overview. The monthly certification form retained in the member's records must include the treating physician's opinion that a failure to receive dialysis at least three times per week would reasonably be expected to result in:

1. Placing the member's health in serious jeopardy, or
2. Serious impairment of bodily function, or
3. Serious dysfunction of a bodily organ or part.

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 (HD) per treatment
841	Continuous Ambulatory Peritoneal Dialysis (CAPD) per day

851	Continuous Cycling Peritoneal Dialysis (CCPD) per day

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

For hospital-based dialysis facility reimbursement, refer to Chapter 11, Hospital Services, of the Fee-For-Service Provider Billing Manual.

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

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, then only one unit should be billed. If the physician bills 30 units for the procedure code for dates of service September 1st through September 30th, then 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, using bill type 72X along with 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 this policy.

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. Antiarrhythmics,
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), and
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. For additional information on pharmacy services please refer to Chapter 12, Pharmacy Services, of the Fee-For-Service Provider Billing Manual.

A free-standing ESRD facility must have appropriate CLIA certification to bill for clinical laboratory services. Laboratory services included in the composite rate, which 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, including the below listed items.

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

- The following if performed *once a week or less frequently*:
  - Prothrombin time for patients on anticoagulant therapy,
  - Creatinine, and
  - BUN.

- The following if performed *once a month or less frequently*:
  - Calcium,
  - Chloride,
  - Total protein,
  - CBC,
  - Bicarbonate,
  - Phosphorous,
  - Total potassium,
  - Albumin,
  - Alkaline phosphatase,
  - SGOT, and

- 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:

- BUN,
- Creatinine,
- Sodium,
- Potassium,
- Carbon Dioxide,
- Calcium,
- Magnesium,
- Inorganic Phosphate,
- Total Protein,
- Albumin,
- Alkaline Phosphatase,
- LDH,
- SGOT,
- Hematocrit (HCT),
- Hemoglobin (HGB), and
- 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 then 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 percent unless medically justified. If the member resides at an elevation above 6,000 feet, a hematocrit of up to 39.5 percent 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 18-28) of the UB-04 claim form. Facilities must bill revenue code 0841 (Continuous ambulatory peritoneal dialysis, per day) or revenue code 0851 (Continuous cycling peritoneal dialysis, per day). If revenue code 0841 or 0851 is billed without condition code 73, claims will be reimbursed the per diem for free-standing dialysis facilities.

Billing for Self-Dialysis Training

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 member and date of service span.

BILLING CPT/HCPCS CODES WITH REVENUE CODES

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.

UB-04 REVENUE – CPT/HCPCS REQUIREMENTS FOR ESRD FACILITIES	
REVENUE CODE	**HCPCS/CPT CODES**
0270 – Med-Sur Supplies & Drug Admin	Various
0304 – Lab/NR Dialysis	83036, 85041
0320 – Dx X-Ray	78350
0380 – Blood	P9022
0381 – Blood/Pkd Red	P9021
0382 – Blood/Whole	P9010
0383 – Blood/Plasma	P9017

0384 – Blood/Platelets	P9019, P9020
0385 – Blood/Leukocytes	P9016
0387 – Blood/Derivatives	P9012
0390 – Blood/Stor-Processing	86000 – 86999
0634/635 – Drug/EPO	Enter the appropriate HCPCS code
0636 – Drugs/Detail Coding	Enter the appropriate HCPCS/CPT code for injections and vaccines administered.
0730 – EKG/ECG	93000, 93005
0771 – Vaccine Administration	G0008, G0009, G0010, 90471, 90472
0821 – Hemo/Composite	90935, 90937, 90999
0841 – CAPD/Composite	90999
0851 – CCPD Composite	90999
0921 – Perivascular Lab	93990
0922 – EMG	95900, 95904

Dialysis Claims with Medicare Coverage

If the member 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. For additional information refer to Chapter 9, Medicare/Other Insurance Liability, of the Fee-For-Service Provider Billing Manual.

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

Medical Review

Fee-For-Service dialysis claims submitted to the AHCCCS Administration are subject to medical review.

Services that are billed separately from the composite rate, because they were provided more frequently than specified by policy, must be justified by supporting documentation. If no documentation is submitted with the claim, or if the documentation does not support the charges, then payment for those services will be disallowed.

References

For further information on covered dialysis services for FESP members refer to AMPM 1120, Federal Emergency Services Program Dialysis.

For further information on prior authorization refer to AMPM 820, Prior Authorization.

Revision History

Date	Description of changes	Page(s)
9/12/2019	References to AMPM 310-E, Dialysis removed since the AMPM policy has been reserved (removed and incorporated into other policies).	Throughout
4/5/2018	Prior authorization information added FESP Member Section updated Billing for Dialysis Services Section updated Medical Review Section updated References Section added	1 1-2 3-7 8 8
1/23/2018	Phone number removed References section added Formatting	1 8-9 All