



Dialysis Clinic Services

*Medicaid and Other Medical
Assistance Programs*



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My NPI/API:

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Key Contacts and Websites

See the Contacts Us link in the left menu on the Montana Healthcare Programs Provider Information website, <http://medicaidprovider.mt.gov/>, for a list of key contacts and websites.

Introduction

Thank you for your willingness to serve members of the Montana Medicaid program and other medical assistance programs administered by the Department of Public Health and Human Services.

Manual Organization

This manual provides information specifically for **dialysis clinics**. It includes a section titled Other Programs with information about other Department programs such as the Mental Health Services Plan (MHSP) and Healthy Montana Kids (HMK). Other essential information for providers is contained in the separate *General Information for Providers* manual. Providers are responsible for reviewing both manuals.

A table of contents and an index allow you to quickly find answers to most questions. There is a list of contacts and websites on the Contact Us link in the menu on the left on the Provider Information [website](#). There is space on the inside of the front cover to record your NPI/API for quick reference when calling Provider Relations.

Manual Maintenance

Manuals must be kept current. Changes to manuals are provided through provider notices and replacement pages. When replacing a page in a paper manual, file the old pages and notices in the back of the manual for use with claims that originated under the old policy.

Rule References

Providers must be familiar with all current Medicaid rules and regulations governing the Montana Medicaid program. Provider manuals are to assist providers in billing Medicaid; they do not contain all Medicaid rules and regulations. Rule citations in the text are a reference tool; they are not a summary of the entire rule. **In the event that a manual conflicts with a rule, the rule prevails.** Links to rule references are available on the Provider Information [website](#). Paper copies of rules are available through the Secretary of State's office. See the Contact Us link in the left menu on the Provider Information [website](#).

In addition to the rules listed in the *General Information for Providers* manual, the following rules and regulations are applicable to the dialysis program:

- Administrative Rules of Montana (ARM)
 - ARM 37.86.4201 through ARM 37.86.4205



Providers are responsible for knowing and following current Medicaid rules and regulations.

Claims Review (MCA 53-6-111 and ARM 37.85.406)

The Department is committed to paying Medicaid providers' claims as quickly as possible. Medicaid claims are electronically processed and usually are not reviewed by medical experts prior to payment to determine if the services provided were appropriately billed. Although the computerized system can detect and deny some erroneous claims, there are many erroneous claims which it cannot detect. For this reason, payment of a claim does not mean that the service was correctly billed or the payment made to the provider was correct. Periodic retrospective reviews are performed which may lead to the discovery of incorrect billing or incorrect payment. If a claim is paid and the Department later discovers that the service was incorrectly billed or paid or the claim was erroneous in some other way, the Department is required by federal regulation to recover any overpayment, regardless of whether the incorrect payment was the result of Department or provider error or other cause.

Getting Questions Answered

The provider manuals are designed to answer most questions; however, questions may arise that require a call to a specific group (such as a program officer, Provider Relations, or a prior authorization unit). For a list of contacts, see the Contact Us link in the left menu on the Provider Information [website](#). Medicaid manuals, provider notices, replacement pages, fee schedules, forms, and more are also available on the Provider Information [website](#).

Covered Services

General Coverage Principles

Medicaid covers most dialysis services when they are medically necessary. This chapter provides covered services information that applies specifically to dialysis clinics. Like all healthcare services received by Medicaid members, dialysis services must also meet the general requirements listed in the Provider Requirements chapter of the *General Information for Providers* manual.

Dialysis Clinic Definitions and Requirements (ARM 37.86.4201–4202)

Dialysis clinics must be licensed to provide services in the state in which the clinic is located. The dialysis clinic must also be certified by the Centers for Medicare and Medicaid (CMS) to provide outpatient maintenance dialysis directly to members with end-stage renal disease (ESRD). Dialysis services are provided to only those members who have been diagnosed by a physician as suffering from chronic ESRD. Supporting documentation must be kept on file.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Program (ARM 37.86.2201–2235)

The EPSDT Well-Child program covers all medically necessary services for children age 20 and under. Providers are encouraged to use a series of screening and diagnostic procedures designed to detect diseases, disabilities, and abnormalities in the early stages. Some services are covered for children that are not covered for adults, such as the following:

- Nutritionist services
- Private duty nursing
- Respiratory therapy
- Therapeutic family and group home care
- Substance dependency inpatient and day treatment services
- School-based services

All prior authorization and Passport approval requirements must be followed. See the *Passport to Health* manual, the Prior Authorization chapter in the *General Information for Providers* manual, and the Prior Authorization Information link in the left menu on the Provider Information [website](#).

For more information about the recommended well-child screen and other components of EPSDT, see the EPSDT Well-Child chapter in the *General Information for Providers* manual.

Coverage of Specific Services

Medicaid follows Medicare's rules for coverage of most services. The following are Medicaid's coverage rules for dialysis services.

Drugs and Biologicals

Most drugs and biologicals used in the dialysis procedure are covered under the composite rate and **may not be billed separately**. Montana Medicaid does not reimburse for any other ESRD-related services other than the dialysis composite rate. For more information regarding billable services, see the Billing Procedures chapter in this manual. The drugs and biologicals used in the dialysis procedure include:

- Heparin
- Mannitol
- Glucose
- Antiarrhythmics
- Pressor drugs
- Dextrose
- Saline
- Antihypertensives
- Protamine
- Antihistamines
- Local anesthetics
- Heparin antidotes

Epoetin (EPO)

Medicaid covers EPO therapy for members who have been diagnosed with chronic ESRD. EPO is covered when administered in a facility; however, it is included in the composite rate.

Hemodialysis and Peritoneal Dialysis Services

Hemodialysis and peritoneal dialysis are covered under a composite rate for the dialysis facility.

Home Dialysis Training (ARM 37.40.901–905)

Medicaid covers training for patients to learn to perform their own dialysis at home and training for a helper/backup person.

Self-dialysis and home dialysis training are programs provided by CMS-certified ESRD facilities that educate ESRD patients and their caregivers to perform self-dialysis in the ESRD facility or home dialysis (including CAPD and CCPD) with little or no professional assistance. Self-dialysis training can occur in the patient's home or in the facility when it is provided by the qualified staff of the ESRD facility. ESRD facilities must be certified through CMS to provide home dialysis training. Information regarding home dialysis training certification may be found at the following link:

<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Dialysis.html>

The facility is reimbursed a training fee amount, found in the current fee schedule on the Provider Information [website](#), in addition to their composite rate, and the amount is dependent on the type of dialysis, as shown below:

- Revenue code 825 Hemodialysis support services
- Revenue code 835 Peritoneal support services
- Revenue code 845 CAPD support services
- Revenue code 855 CCPD support services

Retraining

Occasionally it is necessary to furnish retraining after the initial training is completed. Retraining sessions are paid under any of the following conditions:

- The patient changes from one mode of dialysis to another (e.g., from hemodialysis to CAPD)
- The patient's home dialysis equipment changes
- The patient's dialysis setting changes
- The patient's dialysis partner changes
- The patient's medical condition changes (e.g., temporary memory loss due to stroke, physical impairment)

The patient must continue to be an appropriate patient for self-dialysis.

Home Dialysis Equipment, Support, and Supplies

Medicaid covers home dialysis equipment, support, and supplies. The patient has the option of having the facility provide the equipment under the composite rate, or of renting or purchasing such equipment directly from a supplier. The dialysis facility must provide the home dialysis patient with the following, which are included in the facility's composite rate:

- Periodic monitoring of the patient's home adaptation, including visits to the home, in accordance with a written plan prepared and periodically reviewed by a team that includes the patient's physician and other professionals familiar with the patient's condition.
- Emergency visits by qualified ESRD facility personnel.
- Providing and arranging for supplies when dialysis equipment is provided by the facility.
- Installation and maintenance of dialysis equipment when provided by the facility.
- ESRD-related laboratory tests.
- Testing and appropriate treatment of water.
- Monitoring the dialysis equipment function when provided by the facility.

Some covered support services may involve indirect patient contact. For example, the patient may need to consult with a nurse regarding dietary restrictions or with a social worker if he/she is having problems adjusting. The consultations may be by phone.

Supplies and Equipment

The supplies necessary to administer dialysis (e.g., needles, tubing) are included in the facility's composite rate.

Other Programs

This is how the information in this chapter applies to Department programs other than Medicaid.

Mental Health Services Plan (MHSP)

The information in this manual does not apply to the Mental Health Services Plan (MHSP). Members who qualify for MHSP may receive mental health services in addition to dialysis services. For more information on the MHSP program, see the mental health manual available on the [Provider Information website](#).

Healthy Montana Kids (HMK)

The information in this manual does not apply to HMK/CHIP members. For an HMK/CHIP medical manual, contact Blue Cross and Blue Shield of Montana (BCBSMT) at 1-800-447-7828.

Coordination of Benefits

Medicaid members often have coverage through Medicare, workers' compensation, employment-based coverage, individually purchased coverage, etc. Coordination of benefits is the process of determining which source of coverage is the primary payer in a particular situation.

For Coordination of benefits information, providers should refer to the section on Third Party Liability in the Member Eligibility and Responsibilities chapter of the *General Information for Providers* manual. Medicare coverage is processed differently than other sources of coverage.

Billing Procedures

The following is specific to dialysis clinic services. In addition, providers should refer to the Billing Procedures chapter in the *General Information for Providers* manual.

The Prospective Payment System for ESRD bundles all services provided into a composite rate. ESRD providers will bill dialysis services to Medicaid using only one of the following:

- Revenue code 821 – Hemodialysis composite or other rate
- Revenue code 831 – Peritoneal dialysis composite or other rate
- Revenue code 841 – Continuous ambulatory peritoneal dialysis (CAPD) composite or other rate
- Revenue code 851 – Continuous cycling peritoneal dialysis (CCPD) composite or other rate

Home Dialysis Training

- Revenue code 825 – Hemodialysis support services
- Revenue code 835 – Peritoneal support services
- Revenue code 845 – CAPD support services
- Revenue code 855 – CCPD support services

Revenue codes for dialysis services other than those listed above will bundle and pay at \$0.00. **No other services are paid separately.**

Claim Forms

Dialysis clinic services must be billed either electronically or on a UB-04 claim form. UB-04 forms are available from various publishing companies; they are not available from the Department or Provider Relations.

Member Cost Sharing (ARM 37.85.204 and 37.85.402)

Cost sharing for dialysis services is \$4.00 per visit. See the *General Information for Providers* manual for additional information on member cost sharing.

Remittance Advices and Adjustments

See the *General Information for Providers* manual for more information on remittance advices and adjustments.

How Payment Is Calculated

Overview

Although providers do not need the information in this chapter to submit claims to the Department, the information allows providers to understand how payment is calculated and to predict approximate payment for particular claims.

Dialysis Clinic Rates

Reimbursement for dialysis clinics is based on a bundled composite rate (ARM 37.86.4205). All services provided for a single date of service are bundled into one payment. The fee schedule is subject to periodic adjustment due to changes in appropriated funds and modifications to the Medicare allowed amount for services. Fee schedules are located on the provider type page of the [website](#).

How Payment Is Calculated on TPL Claims

When a member has coverage from both Medicaid and another insurance company, the other insurance company is often referred to as third party liability (TPL). In these cases, the other insurance is the primary payer, and Medicaid makes a payment as the secondary payer. Medicaid will make a payment only when the TPL payment is less than the Medicaid allowed amount.

How Payment Is Calculated on Medicare Crossover Claims

When a member has coverage from both Medicare and Medicaid, Medicare is the primary payer. Medicaid will pay the coinsurance and deductible, less any TPL or incurment, on dialysis claims for these dually eligible individuals.

Payment Examples for Dually Eligible Members

Member has Medicare and Medicaid coverage. A provider submits a dialysis claim for a member with Medicare and Medicaid. The Medicare coinsurance and deductible are \$65.00 and \$185.00. This total (\$250.00) becomes the Medicaid allowed amount. Medicaid will pay this amount (\$250.00) as long as no TPL or incurment amounts are applicable.

Member has Medicare, Medicaid, and TPL. A provider submits a dialysis claim for a member with Medicare, Medicaid, and TPL. The Medicare coinsurance and deductible are \$65.00 and \$185.00. This total (\$250.00) becomes the Medicaid allowed amount. The other insurance company paid \$225.00. This amount is subtracted from the Medicaid allowed amount leaving \$25.00. Medicaid pays \$25.00 for this claim. If the TPL payment had been \$250.00 or more, this claim would have paid at \$0.00.

Member has Medicare, Medicaid, and Medicaid Incurment. A provider submits a dialysis claim for a member with Medicare, Medicaid, and a Medicaid incurment. The Medicare coinsurance and deductible are \$65.00 and \$185.00. This total (\$250.00) becomes the Medicaid allowed amount. The member owes \$150 for his Medicaid incurment, so this amount is subtracted from the \$250.00. Medicaid will pay the provider \$100.00 for this claim.

Definitions and Acronyms

For a list of definitions and acronyms, see the Definitions and Acronyms link in the left menu on the Provider Information [website](#).

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