To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

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Related Clinical Coverage Policies

Refer to https://medicaid.ncdhhs.gov/ for the related coverage policies listed below:
1H: Telehealth, Virtual Communications, and Remote Patient Monitoring

1.0 Description of the Procedure, Product, or Service

Dialysis Services are procedures and services for beneficiaries with chronic renal disease or acute kidney injury designed to replace the functioning of the kidney and maintain the function of related organs. Progressive chronic renal failure typically requires on going dialysis due to End Stage Renal Disease (ESRD), as a result of permanent loss of normal kidney tissues and function.

Hemodialysis, peritoneal dialysis, and self-dialysis support services are covered, as outlined in this clinical policy, when they are provided by a Medicaid & Medicare certified ESRD hospital based renal dialysis center or free-standing ESRD facility for beneficiaries requiring dialysis services.

1.1 Definitions

1.1.1 End-Stage Renal Disease

End Stage Renal Disease is Stage 5 chronic kidney disease requiring maintenance dialysis, defined by the National Kidney Foundation as the inability of native kidneys to properly excrete harmful wastes, concentrate urine, and regulate electrolytes, placing the beneficiary at-risk of dying from kidney failure. Stage 5 means a glomerular filtration rate (GFR) less than 15 milliliter (ml) per min per 1.73 m^2 regardless of kidney damage, or kidney failure treated by dialysis or transplantation.

1.1.2 Acute Kidney Injury (AKI)

Acute kidney injury is a sudden episode of kidney failure or kidney damage that often happens as a complication of another serious illness. AKI causes a build-up of waste products in the blood and makes it hard for the kidneys to keep the right balance of fluid in the body. AKI can also affect other organs such as the brain, heart and lungs. Acute kidney injury is common in patients who are in the hospital, in intensive care units, and especially in older adults.

1.1.3 Dialysis

Dialysis is the process of removing waste products from the body by diffusion from one fluid compartment to another across a semi-permeable membrane. There are two types of renal dialysis procedures in common clinical usage: hemodialysis and peritoneal dialysis. Both hemodialysis and peritoneal dialysis are acceptable types of treatment for kidney injury or disease:

Hemodialysis: is one form of renal replacement therapy during which blood is pumped extracorporally through an artificial kidney machine and the waste products diffuse across a man-made membrane into a bath solution (dialysate). The blood is then cleansed and returned to the body. Access to high blood flow volume is required for hemodialysis. It may be provided by direct arteriovenous anastomosis, arteriovenous (AV) graft (non-autogenous), or by temporary placement of a central venous catheter. Hemodialysis is accomplished usually in 3 to 5-hour sessions, 3 times a week.

Peritoneal Dialysis: Waste products pass from the patient's body through the peritoneal membrane into the peritoneal (abdominal) cavity where the bath solution (dialysate) is introduced and removed periodically. Types of Peritoneal Dialysis

a. **Continuous Ambulatory Peritoneal Dialysis (CAPD)**
In CAPD, the beneficiary's peritoneal membrane is used as a dialyzer. The beneficiary connects a 2-liter plastic bag of dialysate to a surgically implanted indwelling catheter that allows the dialysate to pour into the beneficiary's peritoneal cavity. Every 4 to 6 hours the beneficiary drains the fluid out into the same bag and replaces the empty bag with a new bag of fresh dialysate. This is done several times a day.

b. **Continuous Cycling Peritoneal Dialysis (CCPD)**
In CCPD, the beneficiary uses a machine to automatically fill and drain dialysate from the peritoneal cavity through a surgically implanted indwelling catheter. This process takes about 10 to 12 hours and is done during the night while the beneficiary is sleeping. Upon awakening, the beneficiary disconnects from the cycler and leaves the last 2-liter fill inside the peritoneum to continue the daytime long dwell dialysis.

1.1.4 Home dialysis

Home dialysis is a form of dialysis that is performed at home by an ESRD beneficiary or private caregiver who has completed an appropriate course of training as described in 42 Code of Federal Regulations (CFR) §494.100(a). Home dialysis is not covered for beneficiaries diagnosed with AKI, as they require close medical supervision.

1.1.5 Self-dialysis

Self-dialysis is dialysis that is performed by a beneficiary or private caregiver who has completed an appropriate course of training as specified in §494.100(a). Little or no professional assistance is provided, except in the case of an emergency. This can be performed in centers that have met CMS requirements, or in the ESRD beneficiary's private primary residence (means home for the purpose of this policy), for peritoneal or hemodialysis treatment.

1.1.6 Composite Rate

Composite rate is a bundled payment for renal dialysis items and services for the following: routine laboratory services, drugs, medical equipment and supplies, and support services furnished for dialysis provided by a Medicaid & Medicare certified ESRD hospital based renal dialysis center or freestanding ESRD facility

for beneficiaries requiring dialysis services. Both hospital based and freestanding ESRD facilities are reimbursed for renal dialysis services furnished to beneficiaries with AKI (both adult and pediatric). The same payment methodology is used to reimburse freestanding ESRD facilities for all items and services furnished to beneficiaries with an AKI or ESRD diagnosis.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(*The term "General" found throughout this policy applies to all Medicaid policies*)

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*).
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.1.2 Specific

(***The term "Specific" found throughout this policy only applies to this policy***)

a. <u>Medicaid</u>
None Apply.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. **EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide,* and on the EPSDT provider page. The Web addresses are specified below.

   NCTracks Provider Claims and Billing Assistance Guide: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

   EPSDT provider page: https://medicaid.ncdhhs.gov/

2.3 Undocumented Aliens

Under Federal law, undocumented aliens and certain legal aliens who have not resided in the United States of America for more than five years do not qualify for full Medicaid assistance, but do qualify for medical emergency services. Federal policy (P.L. 104-193 Title IV, 42 C.F.R. §435.406 and §435.350, and section 1903(v) (3) of the Social Security Act) limits Medicaid coverage for services considered to be medical emergencies.

A medical emergency is defined as a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. Each medical emergency must be reviewed on a day-by-day basis to determine whether the alien qualifies for emergency services and, therefore, Medicaid eligibility.

NC Medicaid provides dialysis to undocumented aliens as an emergency service in a facility where licensed professionals monitor the condition of the beneficiary during each episode of care. Once the beneficiary is stable enough to receive in-home hemodialysis

without benefit of the immediate attention of the medical provider, the treatment is no longer an emergency service.

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid shall cover the procedure, product, or service related to this policy when medically necessary, and:

a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.1.1 Telehealth Services

As outlined in **Attachment A,** select services within this clinical coverage policy may be provided via telehealth. Services delivered via telehealth must follow the requirements and guidance set forth in *Clinical Coverage Policy 1-H: Telehealth, Virtual Communications, and Remote Patient Monitoring.*

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by Medicaid

a. Dialysis Services are covered in the composite rate for ESRD facilities as outlined in 1-3 below.
    1. All Dialysis related laboratory services on NC Medicaid's Composite list. For a list of the specific Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes included by Medicaid in the composite rate, refer to **Attachment A, C.**

       Note: The facility may contract with an independent laboratory to provide any or all these inclusive laboratory services, but it is the facility's responsibility to reimburse the independent laboratory company. NC Medicaid shall not directly reimburse the independent laboratories for any dialysis related laboratory service that is included in the composite rate paid to the facility.
    2. All Dialysis related parenteral drugs on NC Medicaid's Composite list. For a list of the specific HCPCS codes included by Medicaid in the composite rate, refer to **Attachment A, C.**
    3. Dialysis treatments are covered by ESRD facilities without documentation of medical necessity as follows:
        A. CAPD and CCPD per date of service, not per treatment; and

B. Hemodialysis up to three times weekly; and cannot exceed more than one dialysis treatment per date of service.

C. Dialysis treatments for AKI provided during the monthly billing cycle. Only one payment for one treatment per day across settings is allowed. In the instance of an uncompleted or partial treatment, additional payment may be allowed.

Note: Providers shall document the first date of the ongoing dialysis treatment on each claim submitted.

b. Providers shall bill dialysis related services once **per calendar month,** using the last day of the month as the date of service.

If a beneficiary dies prior to the last day of the month, the date of death or the last date the beneficiary was seen is entered into the FROM/TO date of service field on the claim detail, instead of the last day of the month.

For a list of the specific CPT procedure codes covered by Medicaid for dialysis under composite reimbursement, refer to **Attachment A, C.**

c. Acute dialysis treatments will continue to be reimbursed in accordance with Outpatient Hospital Reimbursement Methodology when performed in a non-ESRD certified hospital outpatient facility.

d. In addition to the composite rate, ESRD facilities may receive reimbursement for services outlined in 1-7 below. However, at the discretion of NC Medicaid's fiscal agent's representative, a claim can be held pending health records review.

1. **Laboratory services** listed in the composite rate table provided to a beneficiary receiving dialysis for reason(s) other than for treatment of ESRD and AKI.

Note: The nature of the illness or injury (diagnosis, complaint, or symptom) requiring laboratory services must be indicated as the primary diagnosis on the claim. A renal related diagnosis code, submitted as the primary diagnosis, will result in denial of the claim secondary to inclusion in the composite rate.

Laboratory services provided for non- dialysis reasons must be billed by the independent laboratory for reimbursement.

For a list of the specific CPT codes included by Medicaid in the composite rate, refer to **Attachment A, C.**

Designated miscellaneous labs and procedures may be billed by the facility; refer to **Attachment A, C.**

2. When blood administration occurs during a dialysis treatment, supplies used to administer blood and processing fees (e.g. blood typing and cross- matching) may be billed separately.

3. For drugs not included in the composite rate, refer to **Attachment A, C.**

Note: Covered Anemia drugs must have appropriate ESRD or AKI diagnosis codes related to anemia on the claim when billed justifying the medical necessity of the drug administered. If more than allowable units, or dosage of the drug is provided per calendar month, providers shall supply health records such as hemoglobin (HgB) or hematocrit (HCT) laboratory results to demonstrate the medical necessity to justify exceeding covered amounts.

A facility charge for Epogen is not allowed on the same date of service as a physician charge.

4. The following vaccines may be covered separately when administered in the ESRD facility during a dialysis treatment:
   A. Pneumococcal Pneumonia Vaccine (PPV);
   B. Hepatitis B; or
   C. Influenza vaccines.
5. ESRD facility's physician services for Monthly Capitation Payment (MCP) may be reimbursed **per beneficiary per calendar month** for dialysis as follows:
   A. The physician provider group who performs the complete assessment, establishes the beneficiary's plan of care, and provides the ongoing management, shall bill for the MCP service even when a different facility physician provider group provides the visits.
   B. Only one MCP service shall be billed, even if multiple ESRD facility physician provider groups become involved in the beneficiary's care.
   C. The physician may provide up to four face-to-face visit(s) or encounter(s) for the management of the beneficiary.
   D. The physician must provide at least one face-to-face visit per month.

For a list of the specific CPT procedure codes covered by Medicaid for physician services, refer to **Attachment A, C.**

In order to bill for monthly capitation services only one physician provider group may bill at the end of the calendar month. The provider group practice is comprised of the dialysis physician and all other physicians, physician assistants and nurse practitioners in the group.

6. Dialysis physician services may be reimbursed as Daily Capitation Payments when services are provided for **less than a full calendar** when beneficiaries:
   A. travel away from home;
   B. switch from one dialysis type to another;
   C. receive one or more face-to-face visits without a complete assessment;
   D. are hospitalized before a complete assessment is furnished;
   E. stop dialysis services;
   F. receive a kidney transplant;

G. permanently change their dialysis physician provider group; or
H. die

Note: In general, for daily or monthly capitation services: Visits must be furnished face-to-face by the dialysis physician, nurse practitioner, or physician assistant. The type of dialysis, the place of service, age of the beneficiary and the number of physician visits provided determines the CPT code(s) billed.

Monthly and daily dialysis capitation physician services are not allowed in the same calendar month; these claims will deny.

The beneficiary's age at the end of the month is the age used for billing the service.

For a list of the specific CPT procedure codes covered by Medicaid for physician services, refer to **Attachment A, C.**

7. Dialysis training is typically completed within two weeks of initiating self-care and is reimbursed to ESRD facilities when performing one of the following:
   A. CAPD training furnished in sessions that can last up to eight hours per day.
   B. CCPD training furnished in sessions that can last up to eight hours per day,
   C. Hemodialysis training furnished in sessions that can last up to five hours per day.

8. Retraining is reimbursed for beneficiaries receiving dialysis who have already trained in some form of self-dialysis and:
   A. the beneficiary changes from one type of dialysis to another;
   B. the beneficiary's home dialysis equipment changes;
   C. the beneficiary's dialysis setting changes;
   D. the beneficiary's dialysis caregiver changes;
   E. the beneficiary's medical condition changes such as temporary memory loss due to stroke, physical impairment; or
   F. the beneficiary returns to dialysis after a failed renal transplant.

Note: Training and retraining services include training supplies, manuals, materials, and staff time.

For a list of the specific CPT procedure codes covered by Medicaid for training and retraining services, refer to **Attachment A, C.**

3.2.2 Medicaid Additional Criteria Covered

None Apply.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid shall not cover the procedure, product, or service related to this policy when:

a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0;**
b. the beneficiary does not meet the criteria listed in **Section 3.0;**
c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by Medicaid

Medicaid **shall not cover** the following Dialysis Services:

a. office visits, home visits, consults and care plan oversight included in the monthly capitation;
b. access maintenance performed by the staff in the ESRD facility;
c. take home drugs and supplies;
d. specimen collection fees;
e. transportation: The beneficiary is encouraged to contact their local county Department of Social Services for assistance;
f. medical supply charges, including syringes and their administration;
g. costs associated with a private caregiver, outside of allowed training paid to the training facility; and
h. capitation payment for the month in which the training code is billed.

Note: When a beneficiary becomes eligible for Medicare or another third-party payer, Medicaid cannot be billed as the primary payer.

Federal Qualified Health Centers and Rural Health Clinics may not provide dialysis services or any dialysis related services.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

5.1 Prior Approval

Medicaid shall not require prior approval for Dialysis Services.

5.2 Prior Approval Requirements

5.2.1 General

None Apply.

5.2.2 Specific

None Apply.

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

ESRD facilities, as defined in 42 CFR §413.171, shall be certified by Medicare and are required to comply with the Conditions for Coverage set forth in 42 CFR Part 494.

Clinical laboratory services are rendered by medical care entities that are issued a certificate of waiver, registration certificate or certificate of accreditation under the Clinical Laboratories Improvement Amendments of 1988.

6.2 Provider Certifications

None Apply.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

8.0 Policy Implementation/Revision Information

Original Effective Date: July 1, 1973

Revision Information:

Date	Section Revised	Change
08/01/2014	All Sections and Attachment(s)	Initial policy to document current coverage of End-Stage Renal Disease Services under composite rate reimbursement.
10/01/2015	All Sections and Attachment(s)	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
03/15/2019	Table of Contents	Added, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP."
03/15/2019	All Sections and Attachments	Updated policy template language.
07/01/2020	Related Clinical Coverage Policy	1H: Telehealth, Virtual Communications, and Remote Patient Monitoring
07/01/2020	All Sections and attachment(s)	Text additions, deletions and corrections to clarify policy and improve readability.
07/01/2020	Section 1.0	Added, "or Acute Kidney Injury (AKI)" and updated language to include peritoneal dialysis and self-dialysis support services.
07/01/2020	Section 1.1	Added Acute Kidney Injury definition.
07/01/2020	Section 1.1	Added, "Home dialysis is not covered for beneficiaries diagnosed with AKI, as they require close medical supervision."
07/01/2020	Section 1.1	Clarified that dialysis services includes hemodialysis, peritoneal dialysis and self-dialysis support services.
07/01/2020	Section 1.1	"Both hospital-based and freestanding ESRD facilities are reimbursed for renal dialysis services furnished to beneficiaries with AKI (both adult and pediatric). The same payment methodology is used to reimburse freestanding ESRD facilities for all items and services furnished to beneficiaries with an AKI or ESRD diagnosis," replaced, "End Stage Renal Disease Services are provided either in the outpatient renal dialysis center or by the free-standing ESRD facility for in home maintenance dialysis."
07/01/2020	Section 3.1.1	Added Telehealth Services
07/01/2020	Section 3.2.1.a.3	Added, "Dialysis treatments for AKI provided during the monthly billing cycle. Only one payment for one treatment per day across settings is allowed, except in the instance of an uncompleted or partial treatment." Deleted, "When billing services for an undocumented alien, the provider must bill the last day the beneficiary was eligible for the month."

Date	Section Revised	Change
07/01/2020	Section 6.1	"ESRD facilities, as defined in 42 CFR §413.171, shall be certified by Medicare and are required to comply with the Conditions for Coverage set forth in 42 CFR Part 494," replaced "ESRD facilities and hospital based free standing facilities must provide a letter of Certification as a Medicare provider from CMS per State Plan: Attachment 3.1 A.1."
07/01/2020	Attachment A: Claims-Related Information	Added, "Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines. Added ESRD facilities shall report all items and services furnished to beneficiaries with AKI using condition code 84- Dialysis for Acute Kidney Injury (AKI). Deleted, "84265" from Laboratory services included in the composite rate (Not a valid procedure code). Added ESRD facilities must bill with a RC code and a valid drug HCPCS code. Deleted table: Drugs allowed to be billed separately. Deleted, "NDC codes are not to be submitted on claims for vaccines." Clarified that monthly co-payments are required for Dialysis Services. Telehealth guidance added within Modifier and Place of Service sections.
07/01/2020	Table of Contents	Updated policy template language, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP."
12/01/2020	Attachment A: Claims-Related Information	Added daily capitation, monthly capitation and dialysis training codes are eligible for telehealth for new and established patients. Telehealth claims shall include a GT modifier indicating that a service has been provided via interactive audio-visual communication. Added language indicating telehealth codes should be filed with the provider's usual place of service code(s)
12/01/2020	Added beginning of Policy	Added the language "This clinical coverage policy has an effective date of November 15, 2020; however, until the end of the public health emergency, the temporary coverage and reimbursement flexibilities enabled by NC Medicaid through a series of COVID-19 Special Medicaid Bulletins will remain in effect."
08/15/2023	All Sections and Attachments	Updated policy template language due to North Carolina Health Choice Program's move to Medicaid. Policy posted 08/15/2023 with an effective date of 4/1/2023.

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

ESRD facilities shall report all items and services furnished to beneficiaries with AKI using condition code 84 - Dialysis for Acute Kidney Injury (AKI).

Revenue Codes billed for Dialysis Services
RC 821
RC 831
RC 841
RC 851

Laboratory services included in the composite rate

CPT Code(s)				
80047	82374	84100	84525	85044
80048	82435	84105	84540	85045
80051	82436	84132	84545	85046
80053	82540	84133	84550	85048
80061	82565	84134	84560	85049
80069	82570	84155	85002	85060
81000	82575	84156	85004	85610
81002	83020	84157	85007	85611
81003	83021	84160	85008	85730
82040	83026	84165	85009	
82042	83615	84295	85013	
82043	83625	84300	85014	
82044	83735	84450	85018	
82150	84075	84460	85025	
82232	84078	84520	85027	
82310	84080		85041	

All dialysis related laboratory services on NC Medicaid's Composite list **must not be itemized on the provider's claim**. Such itemization will result in a denial of the line item with the explanation of "Routine labs included in the dialysis fees."

Drugs included in the composite rate

HCPCS Code(s)				
J0171	J1200	J1800	J2720	J7042
J0210	J1205	J1940	J2760	J7050
J0360	J1240	J2150	J3410	J7060
J0380	J1640	J2370	J7030	J7070
J1120	J1730	J2690	J7040	J7131
J1160				

To bill for a drug, ESRD facilities must bill with a RC code and a valid drug HCPCS code.

Note: All drugs administered in the ESRD facility require National Drug codes (NDCs) and are subject to NDC edits.

Vaccines allowed to be billed separately

CPT Code(s)
90471
90472
90473
90474
90670

Note: When there is an appropriate North Carolina Immunization Program/Vaccines for Children (NCIP/VFC) vaccine available at no charge to providers for Medicaid children under 19 years of age or beneficiaries who are American Indian/Alaska Native (AI/AN) **and are dialysis patients**, these vaccines should be provided to the beneficiaries by their primary care provider and usually at the time of a wellness check.
NDC codes are to be submitted on claims for vaccines.

Miscellaneous labs and procedures that may be billed separately when medically necessary

CPT Code(s)	Frequency
82108	Once every three months
82728	Once every three months
85048	Once every three months
93000	Once every three months
93005	Once every three months
93010	Once every three months
93040	Once every three months
93041	Once every three months
93042	Once every three months
78300	Once per year
78305	Once per year
78306	Once per year

If the tests are performed in excess of the frequency noted, a specific diagnosis code other than ESRD or AKI is required.

Monthly Capitation codes for a full month of physician reimbursements

CPT Code(s)	Telehealth Eligible Services	CPT Code(s)	Telehealth Eligible Services
90951	Yes	90959	Yes
90952	Yes	90960	Yes
90953	Yes	90961	Yes
90954	Yes	90962	Yes
90955	Yes	90963	Yes
90956	Yes	90964	Yes
90957	Yes	90965	Yes
90958	Yes	90966	Yes

Daily Capitation codes for a partial month of physician service reimbursement billable by the ESRD facility only.

CPT Code(s)	Telehealth Eligible Services
90967	Yes
90968	Yes
90969	Yes
90970	Yes

Self-dialysis training session codes for provider reimbursement

CPT Code(s)	Telehealth Eligible Services
90989 *	Yes
90993**	Yes

Note: Telehealth eligible services may be provided to both new and established patients by the eligible providers listed within this policy.

* Reimbursement for the completed course is allowed once per beneficiary's lifetime.
**Dialysis training sessions are limited to twenty-five sessions per beneficiary's lifetime. Training and retraining sessions are reimbursed at the same rate.

Unlisted Procedure or Service
CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions for Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

D. Modifiers

Non-Telehealth Claims: Provider(s) shall follow applicable modifier guidelines.

Telehealth Claims: Modifier GT must be appended to the CPT or HCPCS code to indicate that a service has been provided via interactive audio-visual communication. This modifier is not appropriate for virtual communications or remote patient monitoring.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

F. Place of Service

Home, ESRD facilities, and independent laboratories.

Telehealth claims should be filed with the provider's usual place of services code(s).

Co-payments
Monthly co-payments are required for Dialysis Services.

For Medicaid refer to the NC Medicaid State Plan:
https://medicaid.ncdhhs.gov/meetings-notices/medicaid-state-plan-public-notices

G. Reimbursement

Provider(s) shall bill their usual and customary charges.
For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/