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1.0 Description of the Procedure, Product, or Service

End-Stage Renal Disease (ESRD) Services are procedures and services for beneficiaries with chronic renal disease designed to replace the functioning of the kidney and to maintain the function of related organs. Progressive chronic renal failure typically require on going dialysis due to ESRD as a result of permanent loss of normal kidney tissues and function. Often there are no symptoms until the kidney has lost more than half its function.

Maintenance hemodialysis and peritoneal dialysis treatments 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 end-stage renal beneficiaries.

1.1 Definitions

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 m² regardless of kidney damage, or kidney failure treated by dialysis or transplantation.

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 modes of treatment for ESRD:

- a. **Hemodialysis** is one form of renal replacement therapy during which blood is pumped extracorporeally 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
- b. **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

1. **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.

2. **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 cyclor and leaves the last 2-liter fill inside the peritoneum to continue the daytime long dwell dialysis.

Home dialysis is dialysis 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).

Self-dialysis is dialysis performed with little or no professional assistance by an ESRD beneficiary or private caregiver who has completed an appropriate course of training as specified in §494.100(a). 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.**

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 maintenance dialysis **provided by** a Medicaid & Medicare certified ESRD hospital based renal dialysis center or free-standing ESRD facility for end-stage renal beneficiaries. End-Stage Renal Disease Services are provided either in the renal dialysis center or in or by the-free-standing ESRD facility for in home maintenance dialysis.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

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

- a. An eligible beneficiary shall be enrolled in either:
 1. the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
 2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) Program on the date of service and shall meet the criteria in **Section 3.0 of this policy.**

- b. Provider(s) shall verify each Medicaid or NCHC 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.
- d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

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

- a. **Medicaid**
None Apply.
- b. **NCHC**
None Apply.

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

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: <http://www.ncdhhs.gov/dma/epsdt/>

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

The Division of Medical Assistance (DMA) shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

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 (5) 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 covers 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 and NCHC 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.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

- a. End- Stage Renal Disease Services are covered in the composite rate for ESRD facilities as outlined in 1-3 below. However, at the discretion of DMA's fiscal agent's representative, a claim can be held pending health records review.
 1. All ESRD-related laboratory services on DMA's Composite list.
For a list of the specific Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes included by Medicaid and NCHC in the composite rate, refer to **Attachment A, C**.
Note: The facility may contract with an independent laboratory to provide any or all of these inclusive laboratory services but it is the facility's responsibility to reimburse the independent laboratory company. DMA shall not directly reimburse the independent laboratories for any ESRD dialysis related laboratory service that is included in the composite rate paid to the facility.
 2. All ESRD related parenteral drugs on DMA's Composite list.
For a list of the specific HCPCS codes included by Medicaid and NCHC in the composite rate, refer to **Attachment A, C**.
 3. Dialysis treatments are reimbursed to ESRD facilities without documentation of medical necessity as follows:
 - A. CAPD and CCPD per date of service, not per treatment.
 - B. Hemodialysis up to three times weekly; and cannot exceed more than one dialysis treatment per date of service.

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

Providers must bill monthly ESRD-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.

When billing services for an undocumented alien, the provider must bill the last day the beneficiary was eligible for the month.

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

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

1. **Laboratory services** included in composite rate table provided to an ESRD beneficiary for reason(s) other than for treatment of ESRD.

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 not included in the composite rate must be billed by the independent laboratory for reimbursement.

For a list of the specific CPT codes included by Medicaid and NCHC 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 diagnosis codes related to anemia on the claim when billed to justify the medical necessity of the drug administered. If more than allowable units/dosage of the drug is billed per calendar month, providers must supply medical records such as hemoglobin (HgB) or hemotocrit (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 reimbursed 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 ESRD beneficiary per calendar month** 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 can be billed, even if multiple ESRD facility physician provider groups become involved in the beneficiary's care.
 - C. The physician may be reimbursed up to four face-to-face visit(s)/encounter(s) for the management of the beneficiary.
 - D. The physician must provide at least one face-to-face visit.

For a list of the specific CPT procedure codes covered by Medicaid and NCHC 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 ESRD physician, his or her nurse practitioner, physician assistant employee or partner.

6. ESRD physician services may be reimbursed as Daily Capitation Payments when services are provided for **less than a full calendar month** as follows:
 - A. transient beneficiaries traveling away from home;
 - B. switch from one dialysis mode to another;
 - C. one or more face-to-face visits without a complete assessment of the beneficiary;
 - D. hospitalization occurred before a complete assessment was furnished;
 - E. dialysis stopped due to death of the beneficiary;
 - F. the beneficiary had a kidney transplant; or
 - G. permanent change in the MCP physician provider group occurred.

Note: In general, for daily or monthly capitation services: Visits must be furnished face-to-face by the ESRD physician, nurse practitioner, or physician assistant. The mode, 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 and NCHC 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.
 - 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.

Retraining is reimbursed for ESRD beneficiaries who have already trained in some form of self-dialysis and:

- i. the beneficiary changes from one mode of dialysis to another; or
- ii. the beneficiary's home dialysis equipment changes; or
- iii. the beneficiary's dialysis setting changes; or
- iv. the beneficiary's dialysis **private caregiver** changes; or
- v. the beneficiary's medical condition changes such as temporary memory loss due to stroke, physical impairment; or
- vi. the beneficiary returns to dialysis after a failed renal transplant.

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

Dialysis training and retraining services are also reimbursed to ESRD facility to train the beneficiary's **private care giver** to perform dialysis.

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

3.2.2 Medicaid Additional Criteria Covered

None Apply.

3.2.3 NCHC 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 and NCHC 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 both Medicaid and NCHC

Medicaid and NCHC **shall not cover** the following End-Stage Renal Disease 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 End-Stage Renal Diseases Services.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

4.2.3 NCHC Additional Criteria Not Covered

- a. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
 1. No services for long-term care.
 2. No nonemergency medical transportation.
 3. No EPSDT.

4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection.”

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 and NCHC shall not require prior approval for End-Stage Renal Disease 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 or NCHC 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

ERSD 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, (effective 07/01/08).

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 DMA'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 Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.

Attachment A: Claims-Related Information

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

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

B. International Classification of Diseases, 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.

Revenue Codes billed for ESRD Facility Dialysis

CPT Code(s)
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	84265	85013	
82043	83625	84295	85014	
82044	83735	84300	85018	
82150	84075	84450	85025	
82232	84078	84460	85027	
82310	84080	84520	85041	

All dialysis related laboratory services on DMA’s Composite list **must not be itemized on the ESRD provider’s claim** when performed for the treatment of ESRD. 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				

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

Drugs allowed to be billed separately

HCPCS Code(s)				
J0882*	Q4081**	90740	90746	90747
90656	90658	90660	90732	

* Darbepoetin Alfa is limited to 1200 units per calendar month.

**Epoetin Alpha (EPO) is limited to 400,000 international units per calendar month

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

ESRD facilities must bill RC code 250 with a valid drug HCPCS code.

Vaccines allowed to be billed separately

CPT Code(s)
90471
90472
90473
90474
90670

Note: When there is an appropriate NCIP/VFC vaccine available at no charge to providers for Medicaid children under 19 years of age or for NCHC beneficiaries who are American Indian/Alaska Native (AI/AN) **and are ESRD 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 not to be submitted on claims for vaccines.

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

CPT Codes	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 is required.

Monthly Capitation codes for a full month of physician service reimbursement

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

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

CPT Codes (s)
90967
90968
90969
90970

Self-dialysis training session codes for ESRD facility reimbursement

CPT Code(s)
90989 *
90993**

* 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

Provider(s) shall follow applicable modifier guidelines.

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.

G. Co-payments

Co-payments are required for End-Stage Renal Disease Services.

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at <http://www.ncdhhs.gov/dma/plan/sp.pdf>.

For NCHC refer to G.S. 108A-70.21(d), located at

http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html

H. Reimbursement

Providers shall bill their usual and customary charges.

For a schedule of rates, see: <http://www.ncdhhs.gov/dma/fee/>