TABLE OF CONTENTS

CHAPTER TWENTY-FOUR

RENAL DIALYSIS

Chapter 24. End Stage Renal Disease Program

Rule No. 560-X-24-.01. End Stage Renal Disease(ESRD) Services - General.

End Stage Renal Disease (ESRD) services are out-patient maintenance services, which may be provided by a free-standing ESRD facility or a renal dialysis center.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 405.2102(e). Rule effective October 1, 1982. This amendment effective January 14, 1987.

Rule No. 560-X-24-.02. Participation

(1) In order to participate in the Title XIX Medicaid Program and to receive Medicaid payment for services, ESRD facilities/centers must meet all the following requirements:

(a) Certification for participation in the Title XVIII Medicare Program

(b) Approval by the appropriate licensing authority

(c) Compliance with Title VI of the Civil Rights Act of 1964 and with Section 504 of the Rehabilitation Act of 1973;

(d) Submission of a letter requesting enrollment; and execution of a contract with the Alabama Medicaid Agency.

(2) Satellites and/or subunits of facilities/centers must be separately approved and execute a contract with Medicaid.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 405.2102,(e)(2)(3), Section 441.40. Rule effective October 1, 1982. This amendment effective January 14, 1987.

Rule No. 560-X-24-.03. Coverage for Outpatient Maintenance Dialysis.

(1) Maintenance dialysis treatments are covered when they are provided by a Medicaid enrolled ESRD hospital-based renal dialysis center or free-standing ESRD facility. The most common elements of a dialysis treatment are overhead costs, personnel services (administrative services, registered nurse, licensed practical nurse, technician, social worker, dietician), equipment and supplies, use of a dialysis machine and its maintenance, ESRD related laboratory tests, certain injectable drugs such as heparin and its antidote, and biologicals. Reimbursement will be based on a composite rate consisting of these elements.

(2) Hemodialysis is defined as the removal of certain elements from the blood by virtue of the difference in the rates of their diffusion through a semipermeable membrane while the blood is being circulated outside the body. Limited to 156 sessions per year which provides for three sessions per week.

(3) Peritoneal dialysis is defined as a process by which waste products and excess fluids are removed from the blood, but unlike hemodialysis where the blood

passes through a machine, peritoneal dialysis is done inside the body. There are two types of peritoneal dialysis that will be covered:

(a) Continuous cycling peritoneal dialysis (CCPD), which requires a machine, and

(b) Continuous ambulatory peritoneal dialysis (CAPD), which does not require a machine. CAPD is a continuous dialysis process that uses the patient's peritoneal membrane as a dialyzer. CCPD and CAPD are furnished on a continuous basis, not in discrete sessions, and will be paid a daily rate, not on a per treatment basis.

Author: Jerri Jackson, RN Analyst, Institutional Services Unit.
Statutory Authority: State Plan;Title XIX, Social Security Act; 42 C.F.R. Section 405.2163.
History: Rule effective October 1, 1982. **Amended:** January 1, 1987; January 14, 1987; August 14, 1991. **Amended:** Filed February 18, 2005; effective May 16, 2005.

Rule No. 560-X-24-.04. Laboratory Services

Laboratory tests listed below are considered routine and are included as part of the composite rate of reimbursement. All other medically necessary lab tests are considered nonroutine and must be billed directly by the actual provider of service.

(a) Hemodialysis

1. Per treatment - All hematocrit and clotting time tests furnished incidentally to dialysis treatments.

2. Weekly - Prothrombin time for patients on anticoagulant therapy; serum creatinine, BUN.

3. Monthly

Serum Calcium	Serum Biocarbonate
Serum Potassium	Serum Phosphorous
Serum Chloride	Total Protein
Alkaline Phosphatase	LDH
SGOT	

(b) Continuous Ambulatory Peritoneal Dialysis (CAPD) Monthly

BUN	Total Protein
Creatinine	Albumin
Sodium	Alkaline Phosphatose
Potassium	LDH
CO2	SGOT
Calcium	HCT
Magnesium	Hgb
Phosphate	Dialysis Protein

(c) All laboratory testing sites providing services to Medicaid recipients, either directly by provider, or through contract, must be Clinical Laboratory Improvement Amendments (CLIA) certified to provide the level of complexity testing

required. Providers are responsible to assure Medicaid that all CLIA regulations are strictly adhered to, both now and as regulations change in the future. Providers are responsible for providing Medicaid waiver certification numbers as applicable.

(d) Laboratories which do not meet CLIA certification standards are not eligible for reimbursement for laboratory services from the Alabama Medicaid Program.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 405.2163. Rule effective October 1, 1982. This amendment effective January 14, 1987. Effective date of this amendment May 13, 1993.

Rule No. 560-X-24-.05. Ancillary Services

(1) Medically necessary take home drugs must be billed under the pharmacy program by the actual provider of services.

(2) Routine parenteral items are included in the facility composite rate and may not be billed separately.

(3) Nonroutine injectables administered by the facility may be billed by the facility actually providing this service. Nonroutine injectables are defined as those given to ameliorate an acute condition such as arrhythmia or infection.

(4) Routine drugs or injectables administered in conjunction with dialysis procedures are included in the facility's composite rate and shall not be billed separately. These include but are not limited to the following:

Heparin	Blucose
Protamine	Dextrose
Mannitol	Antiarrythmics
Saline	Antihistamines
Pressor drugs	Antihypertensives

(5) The administration fee for injectables is included in the facility's composite rate for dialysis and must not be billed separately under a physician provider number.

(6) Reimbursement for procedures cannot exceed the allowable amount under Medicaid. The following procedures are nonroutine and must be billed by the actual provider of service.

(a) 5-76061- Bone Survey-annually (roent-genographic method or photon absorptrometric procedure for bone mineral analysis)

(b) 5-71020- Chest X-ray-every six months

(c) 6-95900- Nerve Conductor Velocity Test (Peroneal NCV) every three months

(d) 6-93000- EKG - every three months

Authority: State Plan, 4.19-E; Title XIX, Social Security Act; 42 C.F.R. Section 416.61, 416.65 and 416.120. Rule effective October 1, 1982. Amended January 14, 1987 and August 10, 1987. Effective date of this amendment November 15, 1989.

Rule No. 560-X-24-.06. Reserved

Rule No. 560-X-24-.07. Physician Services

(1) All physician services rendered to each outpatient maintenance dialysis patient (regardless of the patient's mode of or setting for dialysis) shall be billed on a monthly capitation basis.

(2) Services not covered by the monthly capitation payment MCP) and which are reimbursed in accordance with usual and customary charge rules are limited to:

(a) Declotting of shunts

(b) Covered physician services furnished to hospital inpatients by a physician who elects not to receive the MCP for these services.

(c) Nonrenal related physician services. These services may be furnished either by the physician providing renal care or by another physician. They may not be incidental to services furnished during a dialysis session, or office visit necessitated by the renal condition.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 405.542 (c), and Federal Register (July 2, 1986). Rule effective October 1, 1982. This amendment effective January 14, 1987.

Rule No. 560-X-24-.08. Medicare Deductible and Coinsurance.

Payment for renal dialysis crossover claims shall be made on the basis of a ratio of costs to charges as developed by Medicaid.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 447.300. Rule effective October 1, 1982. This amendment effective January 14, 1987.

Rule No. 560-X-24-.09. Billing and Sending Statement to Eligible Alabama Medicaid Recipients.

(1) No eligible Alabama Medicaid recipient is to receive a bill or statement for covered services or items, once that recipient has been accepted as a Medicaid patient.

(2) The provider may send a notice to the recipient stating their claim is still outstanding, provided the notice indicates in bold letters, "THIS IS NOT A BILL."

(3) It is the responsibility of the provider to follow up with the fiscal agent and/or Medicaid, and not the recipient, on any problem or unpaid claim.

(4) The recipient is not responsible for the difference of covered charges billed and amount paid by Medicaid for covered charges.

(5) Provider may bill eligible recipients for noncovered services.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 447.15, Section 447.50, Section 447.55; Rule effective July 9, 1984. This amendment effective January 14, 1987.