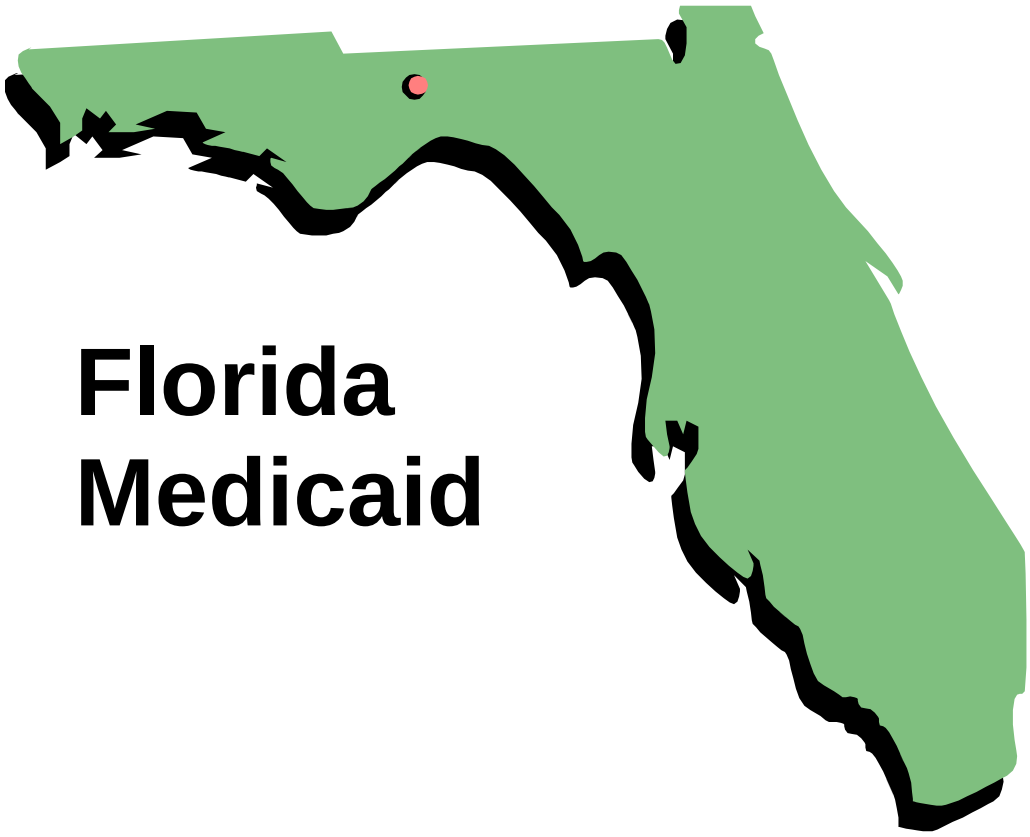

Florida Medicaid

Dialysis Services Coverage Policy

Agency for Health Care Administration

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1.0 Introduction

1.1 Description

Dialysis is a life-support treatment that filters harmful wastes, salt, and excess fluid from an individual's blood. Dialysis services replace the functioning of the kidney and maintain the function of related organs that are compromised as a result of end stage renal disease.

1.1.1 Florida Medicaid Policies

This policy is intended for use by dialysis and hospital providers that render dialysis services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid's general policy and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: Policies are available on the Florida Medicaid fiscal agent's Web site at http://portal.flmmis.com/FLPublic. All policies are incorporated by reference in Rule Division 59G, Florida Administrative Code (F.A.C.).

1.1.2 Statewide Medicaid Managed Care Plans

This Florida Medicaid policy provides the minimum requirements for all providers of dialysis services. This includes providers who contract with Florida Medicaid managed care plans (i.e., provider service networks and health maintenance organizations). Providers must comply with the coverage requirements outlined in this policy, unless otherwise specified in the Agency for Health Care Administration's (AHCA) contract with the Medicaid managed care plan. The provision of services to recipients in a Medicaid managed care plan must not be subject to more stringent coverage than specified in Florida Medicaid policies.

1.2 Legal Authority

Dialysis services are authorized by the following:

- Title 42, Code of Federal Regulations (CFR), Part 494
- Section 409.906(9), Florida Statutes (F.S.)
- Rule 59G-4.105, F.A.C.

1.3 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid definitions policy.

1.3.1 Claim Reimbursement Policy

A policy document that provides instructions on how to bill for services.

1.3.2 Coverage and Limitations Handbook or Coverage Policy

A policy document that contains coverage information about a Florida Medicaid service.

1.3.3 Composite Fee for Dialysis Treatment

Bundled payment for dialysis services including related supplies, laboratory tests, and services. These are the same services included in the Medicare composite rate.

1.3.4 Erythropoietin

An injectable medication that is a copy of a naturally occurring hormone produced primarily by healthy kidneys (also referred to as EPO and Epogen).

1.3.5 Freestanding Dialysis Center

A facility that provides chronic maintenance dialysis services to individuals with end stage renal disease on an outpatient basis.

1.3.6 General Policy
A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1 containing information that applies to all providers (unless otherwise specified) rendering services to recipients.

1.3.7 Hemodialysis
A process by which blood passes through an artificial kidney machine and the waste products diffuse across a manmade membrane into a bath solution known as dialysate, after which the cleansed blood is returned to the patient's body.

1.3.8 Medically Necessary/Medical Necessity
As defined in Rule 59G-1.010, F.A.C.

1.3.9 Peritoneal Dialysis
A process by which 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.

1.3.10 Provider
The term used to describe any entity, facility, person, or group that has been approved for enrollment or registered with Florida Medicaid.

1.3.11 Recipient
For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

2.0 Eligible Recipient

2.1 General Criteria
An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy.

Provider(s) must verify each recipient's eligibility each time a service is rendered.

2.2 Who Can Receive
Florida Medicaid recipients requiring medically necessary dialysis services. Some services may be subject to additional coverage criteria as specified in section 4.0.

2.3 Coinsurance, Copayment, or Deductible
There is no copayment for this service.

3.0 Eligible Provider

3.1 General Criteria
Providers must be at least one of the following to be reimbursed for services rendered to eligible recipients:

- Directly enrolled with Florida Medicaid if providing services through a fee-for-service delivery system
- Registered with Florida Medicaid if providing services through a managed care plan

3.2 Who Can Provide
Facilities certified by the Centers for Medicare and Medicaid (CMS), as required in 42 CFR 494, can provide dialysis services.

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid reimburses services that:

- Are determined medically necessary.
- Do not duplicate another service.
- Meet the criteria as specified in this policy.

4.2 Specific Criteria

4.2.1 Dialysis Treatment

Florida Medicaid reimburses for the following:

- Hemodialysis treatments
- Peritoneal dialysis treatments

The composite fee for dialysis treatment includes all supervision and management of the dialysis treatment routine, durable and disposable medical supplies, equipment, laboratory tests, support services, parenteral drugs and applicable drug categories (including substitutions), and all necessary training and monitoring for recipients receiving peritoneal dialysis treatment.

4.2.2 Erythropoietin Injections

Florida Medicaid reimburses for 500 units (500,000 injectable units) of Erythropoietin (EPO, Epogen) per month.

5.0 Exclusion

5.1 General Non-Covered Criteria

Services related to this policy are not covered when:

- The service does not meet the medical necessity criteria listed in section 1.0.
- The recipient does not meet the eligibility requirements listed in section 2.0.
- The service unnecessarily duplicates another provider's service.

5.2 Specific Non-Covered Criteria

Florida Medicaid does not reimburse for self-administered Erythropoietin.

6.0 Documentation

6.1 General Criteria

For information on general documentation requirements, please refer to Florida Medicaid's recordkeeping and documentation policy.

6.2 Specific Criteria

There are no specific documentation criteria for this service.

7.0 Authorization

7.1 General Criteria

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary.

For recipients enrolled in a managed care plan, providers should request authorization through the recipient's managed care plan. For recipients receiving services through the fee-for-service delivery system, providers should request authorization through the Quality Improvement Organization. For more information on general authorization submission requirements, please refer to Florida Medicaid's authorization policy.

7.2 Specific Criteria

The authorization information described below is applicable to the fee-for-service delivery system, unless otherwise specified.

There are no specific authorization criteria for this service.

8.0 Reimbursement

8.1 General Criteria

The reimbursement information below is applicable to the fee-for-service delivery system, unless otherwise specified.

8.2 Specific Criteria

All pharmaceutical claims for injectable medications must include National Drug Codes (NDC) to permit the invoicing for federal or state supplemental rebates from manufacturers. Claims for drug products that do not include NDC information are not reimbursed unless the drug product is exempt from federal rebate requirements.

8.3 Claim Type

Institutional (837I/UB-04)

8.4 Hospital Billing Code, Modifier, and Billing Unit

Providers must report the most current and appropriate billing code(s), modifier(s), and billing unit(s) for the service rendered, as incorporated by reference in Rule 59G-4.002, F.A.C.

No modifiers are required when billing Florida Medicaid for Erythropoietin.

8.5 Diagnosis Code

Providers must report the most current and appropriate diagnosis code to the highest level of specificity that supports medical necessity, as appropriate for this service.

All claims for dialysis services rendered to individuals with end stage renal disease must be billed with diagnosis code N18.6.

8.6 Rate

For a schedule of rates, as incorporated by reference in Rule 59G-4.002, F.A.C., visit the Florida Medicaid fiscal agent's Web site at http://portal.flmmis.com/flpublic.