Dialysis: Chronic Dialysis Services

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‹‹Dialysis facilities must use the HCPCS codes referenced in this section to bill for maintenance dialysis or home dialysis.

For End Stage Renal Disease information, refer to the *Dialysis: End Stage Renal Disease Services* section in the appropriate Part 2 manual. For additional billing assistance, refer to the *Dialysis Examples: UB-04* section of this manual.››

Maintenance Dialysis

HCPCS Codes

The following HCPCS codes are used to bill for maintenance dialysis.

Professional Charges and Routine Laboratory Services

HCPCS Code	Description
Z6004	Maintenance dialysis including routine laboratory services. Professional fee is billed separately on the *CMS-1500* claim.
Z6006	Maintenance dialysis only. Routine laboratory services are billed separately.

Laboratory Services for Maintenance Dialysis and Training Codes

If routine laboratory services are not included in the composite rate for dialysis maintenance and training codes, they should be billed separately by either:

1. The dialysis facility itself on the *UB-04* claim if the facility has a category of service to bill for laboratory services; or
2. An outside clinical laboratory on the *CMS-1500* claim.

   The professional fee is billed on the *CMS-1500* claim

Dialysis HCPCS Codes Rates

The following HCPCS code rates became effective on August 1, 2001:

HCPCS Code	Description	Reimbursement Rate
Z6004	Maintenance dialysis including routine laboratory services. Professional fee is billed separately on the *CMS-1500* claim.	$141.31
Z6006	Maintenance dialysis only. Routine laboratory services are billed separately.	$136.19

Dialysis Maintenance and Training: Same Day Billing Restrictions

Medi-Cal maintenance dialysis (HCPCS codes Z6004 and Z6006) will not be reimbursed if billed by the same provider for the same recipient on the same date of service as a Centers for Medicare & Medicaid Services (CMS)-approved dialysis exception rate (HCPCS code Z6020).

Home Dialysis

The following HCPCS codes are used to bill for home dialysis.

HCPCS Code	Description	‹‹**Reimbursement Rate**››
S9335	Home therapy, hemodialysis; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing services coded separately), per diem.	‹‹$84.50››
S9339	Home therapy; peritoneal dialysis, administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem.	‹‹$60.37››

HCPCS codes S9335 and S9339 are reimbursed on a single monthly claim by using the “from-through” billing method.

Composite Rates

Composite rates include laboratory services (monthly testing), support services and dialysis equipment.

Laboratory Services

The following laboratory services (monthly testing) are included in the composite rate for home dialysis:

- BUN
- Creatinine
- Sodium
- Potassium
- Bicarbonate
- Calcium
- Magnesium
- Phosphate
- Total Protein and Albumin
- Alkaline Phosphatase
- LDH
- SGOT
- HCT and Hgb
- Dialysate Protein

Support Services Under the Composite Rate

The following support services are included in the composite rate for home dialysis:

- Periodic monitoring of patient's adaptation to home dialysis and performance of dialysis.
- Visits by trained technical personnel made in accordance with a plan prepared and periodically reviewed by a professional team that includes a physician.
- For CAPD patients: changing the connecting tube (also referred to as administration set), watching the patient perform CAPD and assuring that it is done correctly, instruct the patient to avoid or detect peritonitis and inspect the catheter site.

Equipment Not Covered for CAPD Patients

The provision of any dialysis equipment is included in the composite rate. However, it should be noted that CAPD does not require the use of any equipment or water testing because the dialysate is prepared and delivered by the manufacturer. Therefore, a dialysis machine, water testing and water treatment are not covered for CAPD patients.

Other Policies

CMS-Approved Dialysis Exception Codes

Some dialysis facilities have higher reimbursement rates approved by the Centers for Medicare & Medicaid Services (CMS). These exception codes are:

HCPCS Code	Description
Z6020	Maintenance dialysis including routine laboratory services (CMS approved)

‹‹The exception code definition corresponds to the definitions for the maintenance dialysis codes (Z6004 and Z6006).››

Dialysis Maintenance and Training: Same Day Billing Restrictions

‹‹Medi-Cal maintenance dialysis (HCPCS codes Z6004 and Z6006) will not be reimbursed if billed by the same provider for the same recipient on the same date of service as a CMS-approved dialysis exception rate (HCPCS codes Z6020).››

Exception Code Rate Changes

Providers with exception code rates approved by CMS must notify the Department of Health Care Services (DHCS) when their rates change. Send the procedure codes affected, the rate approved by CMS, and the effective date of the rate to:

Department of Health Care Services
Rates Development Branch
MSC 4600
1501 Capitol Avenue, Suite 71.4001
P.O. Box 997413
Sacramento, CA 95899-7413

Laboratory Tests

Laboratory tests for hemodialysis, continuous ambulatory peritoneal dialysis (CAPD), intermittent peritoneal dialysis (IPD) and continuous cycling peritoneal dialysis (CCPD) are billed as routine tests or separately billable items based on the type of test.

Routine Tests

Hemodialysis, CAPD, IPD and CCPD routine tests are conducted as listed below.

Hemodialysis

Hemodialysis routine tests can be conducted per treatment, weekly or monthly:

Frequency	**Treatment**
Per Treatment (13 per month)	Hematocrit, clotting time
Weekly (4 per month)	BUN Prothrombin time for patients on anticoagulant therapy Serum creatinine
Monthly (1 per month)	Alkaline phosphatase Bicarbonate Chloride LDH Phosphorus Potassium Serum albumin Serum calcium SGOT Total protein Dialysite Protein Magnesium Sodium

CAPD, IPD and CCPD

CAPD, IPD and CCPD routine tests are conducted on a monthly basis (1 per month) for BUN, serum creatinine, sodium, potassium, bicarbonate, calcium, magnesium, phosphate, total protein, albumin, alkaline phosphatase, LDH, SGOT, HCT, Hgb and dialysate protein.

Routine Test Exceeded

Routine laboratory services that exceed the frequency in the dialysis composite rate, may be reimbursed if medical justification is included in the *Remarks* field of the claim.

Medical Justification

A diagnosis of End State Renal Disease (ESRD) alone is not sufficient medical evidence to warrant coverage of the additional test.

Separately Billable Tests *

Separately billable tests for hemodialysis are as follows:

Frequency	Treatment
Once every three months	EKG Serum Ferritin
Once every six months	Chest X-ray Nerve conduction velocity
Once per year	Bone survey

Separately billable tests for CAPD, IPD and CCPD are as follows:

Frequency	Treatment
Once every three months	Platelet count RBC WBC
Once every six months	24-hour urine volume Chest X-ray EKG Nerve conduction velocity Residual renal function

Separately billable tests for Hepatitis B testing are as follows:

- For dialysis patients with unknown hepatitis status, test for all markers of HBV infection (HBsAg, anti-HBc, and anti-HBs).
- Serologic testing 1 to 2 months after administration of the final dose of the primary vaccine series to determine the need for revaccination.
- Annual testing for antibody to Hepatitis B surface antigen (anti-HBs) to assess the need for Hepatitis B vaccine booster doses.
- Test vaccine non-responders monthly for HBsAg.

These services may be billed using ICD-10-CM code Z23.

Note: Chronic dialysis facilities, with Provider Type 42 and Category of Service code 21, will not be reimbursed separately for laboratory tests. These tests must be referred to the appropriate outside clinical laboratory for processing.

From-Through Billing

‹‹Facilities must bill HCPCS codes Z6004, Z6006 or Z6020 in the “from-through” format if more than one date of service is billed.›› The dates for the dialysis treatment must be listed in the Description field (Box 43) of the claim.

‹‹HCPCS code Z6034 cannot be billed in the “from-through” format.››

When more than 14 dialysis treatments are provided in one calendar month, the dates on which the physician saw the patient must be indicated in the Remarks field on the claim. (Refer to the Dialysis Examples: UB-04 section of this manual for an example of “from-through” billing.)

Injections and Supplies

Chronic Outpatient Hemodialysis

Laboratory services necessary for chronic outpatient hemodialysis in renal dialysis centers and community hemodialysis units are payable only when billed by the renal dialysis center or community hemodialysis.

Alteplase

Alteplase is indicated for the restoration of function to the central venous access devices as assessed by the inability to withdraw blood and is separately reimbursable to dialysis centers. It is not included in the composite rates for dialysis maintenance and training codes billed by dialysis centers.

Dosage

The recommended dose is 2 mg in 2ml instilled into the dysfunctional catheter. If catheter function is not restored at 120 minutes, a second dose may be instilled.

Billing

HCPCS code

J2997 (injection, alteplase recombinant, 1mg)

Supplies

Supply items other than those included in the composite rate may be billed by the clinic using CPT® code 99070. Dialysis facilities must bill this code with ICD-10-CM codes N18.1 thru N19 (chronic kidney disease and unspecified kidney failure). HCPCS code Z7610 must not be used to bill for dialysis supplies.

Composite Rates: Supplies and Drugs

The composite rate for dialysis covers:

- All durable and disposable items and medical supplies necessary for the effective performance of a patient's dialysis.
- Supplies including, but not limited to:
  - Forceps
  - Sphygmomanometer with cuff and stethoscope
  - Syringes
  - Alcohol wipes
  - Sterile drapes
  - Needles
  - Topical anesthetics
  - Rubber gloves
  - Dialysate heaters
  - Dialysate
  - Connecting tubes
- Certain parenteral items used in the dialysis procedure. These items may not be billed separately. Drugs used as a substitute for any of these items, or to accomplish the same effect, also are covered under the composite rate. The following drugs are included under the composite rate:
  - Heparin
  - Protamine
  - Mannitol
  - Saline

- Pressor drugs
- Glucose
- Dextrose
- Antihistamines
- Antiarrhythmics
- Antihypertensives

Drugs Separately Billed

Drugs that must be billed separately include antibiotics, anabolics, analgesics, tranquilizers, hematinics, muscle relaxants and sedatives.

Injections

Separately reimbursable injections must be billed with the appropriate HCPCS injection code. (Refer to the Injections: Code List section of this manual.) If no specific injection code exists, use CPT codes 96372 (therapeutic, prophylactic or diagnostic injection [specify substance or drug]; subcutaneous or intramuscular]) or 96379 (unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion).

Note: CPT code 96379 requires an approved TAR for reimbursement.

Epoetin Alfa

Epoetin alfa can be used to treat anemia due to:

- Chronic Kidney Disease (CKD) in patients on dialysis and not on dialysis.
- Anti-retroviral therapy in HIV-infected patients.
- The effects of myelosuppressive chemotherapy in patients with non-myeloid malignancies and upon initiation, there is a minimum of two additional months of planned chemotherapy.
- Reduction of allogeneic RBC transfusion in patients undergoing elective, noncardiac, nonvascular surgery.
- Myelodysplastic syndromes.

‹‹Refer to the *Injections: Drugs E Policy* section of this manual for more information.››

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.