ESRD Maximum Units of Service and Modifier Policy
Policy Number: PI205

Molina's Policy Purpose Statement

This policy is intended to ensure correct provider reimbursement and serves only as a general resource for Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to affect care decisions. This policy was developed using nationally accepted industry standards and coding principles. In a conflict, federal and state guidelines, as applicable, and the member's benefit plans supersede the information in this policy. Also, to the extent of conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were correct at the time of policy approval. If there is a state exception, please refer to the state exception table listed below.

Line of Business

☒ Medicaid ☒Medicare ☒Marketplace ☒ Duals

Policy Overview

End Stage Renal Disease (ESRD) results from the progressive destruction of normal kidney tissues over an extended period. Dialysis is a medical procedure that removes waste products from the body through diffusion across a semi-permeable membrane from one fluid compartment to another. There are two primary types of dialysis: hemodialysis (HD) and peritoneal dialysis (PD). Hemodialysis involves a machine that filters waste, salt, and fluids from the blood, typically performed in a dialysis center or at home with specialized equipment. Peritoneal dialysis uses the lining of the abdomen (peritoneum) as a natural filter and can be administered either in a dialysis center or at home.

Peritoneal dialysis can be further categorized into Intermittent Peritoneal Dialysis (IPD), Continuous Ambulatory Peritoneal Dialysis (CAPD), and Continuous Cycling Peritoneal Dialysis (CCPD). Intermittent Peritoneal Dialysis (IPD) involves using the peritoneum to filter waste and excess fluid from the blood periodically, usually conducted at a healthcare facility. Continuous Ambulatory Peritoneal Dialysis (CAPD) is performed continuously throughout the day without requiring a machine, with the patient manually exchanging the dialysis fluid several times daily. Continuous Cycling Peritoneal Dialysis (CCPD) employs a machine to automatically cycle dialysis fluid in and out of the abdomen, typically during the patient's sleep, providing continuous treatment overnight.

Reimbursement Guidelines

Dialysis is typically administered three times per week, with each session lasting between 3 and 5 hours. The maximum number of treatments in a month is thirteen sessions during a 30-day calendar month or fourteen sessions during a 31-day calendar month. Should the ESRD facility charge for treatments that exceed this standard frequency, medical justification must be provided, proving it is necessary based on the individual patient's specific needs. Molina Healthcare will review the medical justification for each added treatment and handles deciding the appropriateness of the extra treatments and authorizing payment for these added sessions.

For reference, the CMS Guidelines about the frequency of dialysis for Medicare patients are detailed below.

Type	In-Facility
Hemodialysis	Three per week
Hemofiltration	Three per week
Ultrafiltration	Three per week
Peritoneal Dialysis (e.g., CAPD and CCPD)	Hemodialysis-equivalent sessions
Intermittent Peritoneal Dialysis (IPD)	Three per week

Billing and Coding Guidelines for Dialysis

- Dialysis, whether performed at a free-standing dialysis facility, or performed outpatient at a hospital, is billed on a UB-04 form, or its electronic equivalent.
- Monthly ESRD services are sent on the UB-04 form, or its electronic equivalent, with a 72X type of bill (TOB). 72X type of bill (TOB) shows Hospital-Based or Independent Renal Dialysis. The "X" will be replaced with either a "1", "2", "3", "4", "7" or "8" depending on the patient's circumstances.

- Field 6 on the UB-04 form, or its electronic equivalent, states, “Statement Covers Period From ____ Through _____”. ESRD services are subject to monthly billing guidelines for recurring treatments. The “From” and “Through” dates on the statement should be the first day of dialysis in the billing month through the final day of dialysis within the same billing period.
- Condition Codes – fields 18 through 28 on the UB-04 form, or its electronic equivalent.
  - Each dialysis claim must include one condition code to specify the dialysis setting. A choice should be made among condition codes 71, 72, 73, 74, or 76.
  - Condition codes 59, 70, 80, 84, 86, and 87 are optional condition codes that can be used with condition codes 71, 72, 73, 74, or 76.
  - If two different dialysis settings are used within the month, two separate claims must be sent. It is recommended to file each claim covering the entire range of dates for the relevant dialysis type, ending with the last day of dialysis performed during the billing month.

UB-04 Condition Code	UB-04 Condition Code Definition
59	Non-primary ESRD facility. Provider reports this code to show the ESRD beneficiary received non-scheduled or emergency dialysis services at a facility other than his/her primary ESRD dialysis facility.
70	Self-administered erythropoietin alpha (EPO). Code shows the billing is for a home dialysis patient who self-administers EPO or darbepoetin alpha.
71	Full care in unit. The billing is for a patient who receives staff-assisted dialysis services in a hospital or renal dialysis facility.
72	Self-Care in unit. The billing is for a patient who managed his/her own dialysis services without staff aid in a hospital or renal dialysis facility.
73	Self-Care training. The bill is for special dialysis services where a patient and his/her helper (if necessary) were learning to perform dialysis.
74	Billing is for a patient who receives dialysis services at home.
76	Back-up dialysis in-facility. The bill is for a home dialysis patient who received back-up dialysis in a facility.
80	ESRD beneficiary receiving home dialysis in nursing facilities, including skilled nursing facilities (report along with code 74).
84	Dialysis for Acute Kidney Injury (AKI) monthly.
86	Other hemodialysis treatments with medical justification.
87	ESRD self-care retraining.

List each service on its own line with the correct date of service. Dialysis claims must include detailed billing, such as revenue codes, HCPCS or supply codes, CPT codes, and modifiers. Molina Healthcare checks dialysis claim dates to prevent overlaps with other processed claims, avoiding errors and flagging only duplicate items.

Revenue Code	Revenue Code Definition
0300	Laboratory.
0634	EPO, less than 10,000 units administered.
0635	EPO, 10,000 units or more administered.
0636	Darbepoetin Alfa and drugs requiring specific information.
082X	Hemodialysis
083X	Peritoneal dialysis
084X	Continuous Ambulatory Peritoneal Dialysis (CAPD)
085X	Continuous Cycling Peritoneal Dialysis (CCPD)
0881	Ultrafiltration, performed separately from dialysis treatment.

Dialysis CPT Codes	Dialysis CPT Code Description
90935	Hemodialysis procedure with single evaluation by a physician or other qualified health care professional.

90937	Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription.
90945	Dialysis procedures other than hemodialysis (e.g., peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), with single evaluation by a physician or other qualified health care professional.
90947	Dialysis procedures other than hemodialysis (e.g., peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies) require repeated evaluations by a physician or other qualified health care professional, with or without substantial revision of dialysis prescription.
90951	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include checking the adequacy of nutrition, assessment of growth and development, and counseling of parents; with four or more face-to-face visits by a physician or other qualified health care professional per month.
90952	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month.
90999	Unlisted dialysis procedures, applicable in both inpatient and outpatient settings. Used for a dialysis service that cannot be classified under any existing CPT codes.

The following are drugs typically administered during dialysis, and their listed HCPCS supply code. Drugs supplied during dialysis also needs to be billed for on a UB-04 or its electronic equivalent, and with their own date of service, revenue code and HCPCS supply code. Please note, this is not an all-inclusive list of drugs that may be administered during dialysis.

Dialysis HCPCS Code	Dialysis HCPCS Code Description
J0882	Injection, Darbepoetin alfa, one microgram (for ESRD on dialysis) (Aranesp).
J0887	Injection, Epoetin beta, one microgram, (for ESRD on dialysis)
Q4081	Injection, Epoetin alfa, one hundred units (for ESRD on dialysis).
Q5105	Injection, Epoetin alfa-epbx, biosimilar, (retacrit) (for ERSD on dialysis), one hundred units

The following ICD-10-CM diagnosis codes are commonly used on dialysis claims:

ICD-10-CM Diagnosis Code	ICD-10-CM Diagnosis Code Description
N18.5	End Stage Renal Disease.
N18.6	Dialysis status (used for patients currently receiving dialysis).
N18.3	Chronic kidney disease, stage 3 (moderate).
N18.4	Chronic kidney disease, stage 4 (severe).
I12.9	Hypertensive heart AND chronic kidney disease, unspecified (for patients whose CKD is a result of hypertension).
E11.22	Type 2 diabetes mellitus with diabetic nephropathy (for patients whose CKD is due to diabetes)
Secondary codes	Extra codes might be needed to specify the underlying condition that leads to ESRD, such as diabetes, high blood pressure, or other kidney-related diseases.

The following modifiers are commonly used on dialysis claims. Please note this is not an all-inclusive list of modifiers that can be used on dialysis claims.

Modifier	Modifier Description
25	It shows that a distinct and substantial evaluation and management (E/M) service was delivered on the same day as the dialysis treatment.
59	Applied when a procedure is conducted independently of other procedures on the same day.
CG	Submit with revenue codes 0821 or 0881 and CPT code 90999 when invoicing for dialysis treatments that exceed the allowable 13 or 14 treatments per month. See below for more information.
KX	Specific required documentation on file. Submit with CPT code 90999 when invoicing for dialysis treatments that exceed the allowable 13 or 14 treatments per month. See below for more information.
PO	Shows that the dialysis treatment was administered in an outpatient environment.

Modifier Policy

Each dialysis session provided beyond the standard three sessions per week should be billed under code 90999 for every line of these services. This applies even if the standard three sessions per week were billed under a different dialysis CPT code. Sessions billed beyond the three sessions per week should also be billed with either the modifier CG or the modifier KX.

When to use the CG modifier with CPT code 90999: Send with revenue codes 0821 or 0881. Modifier CG shows that the added sessions are not considered medically necessary. This modifier confirms that the facility asserts that the extra treatment does not meet the required medical criteria. Claims for treatments without proper medical justification will not be paid, and non-covered treatments will not be included in the outlier payment calculation. However, these extra sessions will be used in data analysis.

When to use the KX modifier with CPT code 90999: Additional hemodialysis sessions may be covered within a month if they are decided by a licensed healthcare provider acting within their professional scope. Furthermore, a physician order is needed for these extra medically necessary sessions. This information must be documented in the medical records and made available upon request.

Hemodialysis performed or billed more than three times per week is considered reasonable and medically necessary for certain patient conditions, such as hyperkalemia, pregnancy, volume overload, acute pericarditis, congestive heart failure, pulmonary edema, or severe catabolic state, when these conditions do not respond to dialysis three times a week.

Definitions

Term	Definition
AKI	Acute Kidney Injury. Acute Kidney Injury (AKI) refers to the sudden and rapid decline in kidney function, leading to an inability to filter waste products and support the balance of fluids and electrolytes in the body. This condition can develop over a few hours or days and is often shown through an increase in serum creatinine levels or a decrease in urine output. AKI can result from various causes, including dehydration, infections, medications, blockages in the urinary tract, or pre-existing kidney diseases. It is a serious condition that requires immediate medical attention to prevent complications such as kidney failure.
CKD	Chronic Kidney Disease. Chronic Kidney Disease (CKD) is a long-term condition where the kidneys gradually lose their ability to function properly over time, and progress slowly, often over many years. The kidney's ability to filter waste, regulate fluid balance, and support electrolyte levels diminishes, leading to the accumulation of waste products and fluids in the body. CKD is typically caused by conditions such as high blood pressure, diabetes, and other factors that damage the kidneys over time.
CMS	The Centers for Medicare & Medicaid Services. The Centers for Medicare & Medicaid Services (CMS) is a federal entity under the United States Department of Health and Human Services (HHS). It oversees the Medicare program and collaborates with state governments to manage Medicaid, the Children's Health Insurance Program (CHIP), as well as health insurance portability regulations.
CPT Codes	Current Procedural Terminology. Used by physician offices and physicians and clinicians in all settings, outpatient hospital facilities, outpatient dialysis centers, and ambulatory surgery centers. CPT codes are used to report most procedures on claims that are sent.
ESRD	End Stage Renal Disease. End-Stage Renal Disease (ESRD) is the final stage of chronic kidney disease (CKD), where the kidneys have lost all their ability to function, typically with only 10-15% of kidney function remaining. At this stage, the kidneys can no longer effectively filter waste products, excess fluids, or support the balance of electrolytes in the body, leading to dangerous levels of waste and fluid buildup. ESRD needs dialysis (a treatment that mimics kidney function) or a kidney transplant to sustain life. Common causes of ESRD include uncontrolled diabetes, hypertension, and prolonged CKD.
HCPCS Codes	Used by physician offices, outpatient hospital facilities, inpatient, outpatient dialysis centers, and ambulatory surgery centers. Medicare mandates that providers (regardless of the type of provider) use alphanumeric HCPCS codes to report various biologicals, drugs, devices, supplies, and certain services.
ICD-10-CM Diagnosis Codes	The International Classification of Diseases, Tenth Revision, Clinical Modification. The ICD-10-CM is a standardized classification system used for coding data related to diseases and medical conditions (morbidity). Healthcare professionals use ICD-10-CM codes when documenting diagnoses for patients.
Modifiers	Two-digit modifiers are two-character codes used to provide more information about a service or procedure. They are added to the CPT or HCPCS codes to show specific details about how a procedure was performed, any unusual circumstances, or any adjustments that might apply to the standard billing.
ODM	Ohio Department of Medicaid
Revenue Codes	Revenue codes are numerical codes used by healthcare facilities and hospitals to categorize and bill for services provided to patients. Revenue codes help healthcare providers specify the type of service, procedure, or item provided. Revenue codes are used in conjunction with ICD-10-CM codes (for diagnoses) and CPT or HCPCS codes (for procedures and services) to create a complete billing record.
UB-04 Condition Code	A two-digit code used to show specific conditions or circumstances that may affect the billing of services given. These codes provide more context for the payer, helping to explain why certain services were provided or why certain billing procedures were used. The correct use of condition codes helps the player understand specific scenarios tied to a patient's care, such as coordination of benefits, or unusual circumstances surrounding the claim.

State Limitations and Exclusions

State	Exception
AZ	❖ Dialysis is paid at a composite rate. Services included in this rate cannot be billed separately unless provided more often than specified. ❖ Hospitals with Medicare-certified outpatient dialysis facilities must separate claims for dialysis services from other outpatient services. ❖ Free-standing renal dialysis facilities must bill all charges for one month on a single UB-04 claim form. Split billing is not allowed and will result in denial. ❖ To bill for self-dialysis training, approved free-standing dialysis facilities must use condition code 73 in any condition code field (Fields 18-28) on the UB-04 form, along with revenue codes 0841 or 0851. Without condition code 73, reimbursement will be per diem. ❖ Do not bill for self-dialysis training on the same claim form as other dialysis services. Use a separate form to ensure correct processing and assignment of a distinct AHCCCS Claim Reference Number (CRN).
KY	❖ The state of Kentucky acknowledges that dialysis patients undergo treatment three times per week, with each session lasting up to five hours.
MA	❖ When billing for dialysis, Massachusetts only recognizes CPT codes 90989, 90993, and 90999. All other CPT codes require prior authorization. ❖ CPT Code 90989: Dialysis training for the patient, including a helper where applicable, any mode, completed course. ❖ CPT Code 90993: Dialysis training for the patient, including a helper where applicable, any mode, course not completed, per training session. ❖ CPT Code 90999: Unlisted dialysis procedure, inpatient, or outpatient (all-inclusive service per dialysis treatment per patient).
MI	❖ The Michigan Department of Health and Human Services (MDHHS) adheres to Medicare's billing requirements for outpatient and emergency outpatient dialysis services, such as using the proper diagnosis code, patient weight, height, and other relevant information. However, the coverage and reimbursement policies are different. ❖ Reimbursement for freestanding dialysis centers (End-Stage Renal Disease facilities) follows Medicaid's Outpatient Prospective Payment System (OPPS).
MS	❖ The Division of Medicaid funds three (3) units of hemodialysis per seven (7) day week. ❖ Medical documentation proving the medical necessity for more units is needed. ❖ The Division of Medicaid reimburses freestanding and hospital-based ESRD facilities at the bundled ESRD PPS rate for all resources used in providing outpatient dialysis services. This includes supplies, equipment used to administer dialysis in the ESRD facility or at a beneficiary's home, drugs, biologicals, laboratory tests, and support services. ❖ Evaluation and management services provided to the beneficiary that are unrelated to dialysis services cannot be performed during the dialysis session and must be reported separately.
NE	❖ FOR PHYSICIANS ONLY: Nebraska Medicaid follows Medicare's guidelines for coverage of dialysis.
NV	❖ Nevada Medicaid reimburses ESRD facilities and outpatient hospitals with a bundled prospective payment system (PPS). The PPS will include all resources used in providing outpatient dialysis treatment, including biological, drugs and laboratory services. ❖ Nevada Medicaid only recognizes two CPT codes for ESRD dialysis services: ❖ 90945 - Dialysis procedure other than hemodialysis, with single evaluation by a physician or other qualified health care professional. ❖ 90999 - Unlisted dialysis procedure, which will include all treatment associated with ESRD services. ❖ Covered ESRD services do not require prior authorization except for out-of-state services. If an established recipient in Nevada needs to travel out of state, the provider or the facility must start contact and make financial arrangements with the out-of-state facility before sending a prior authorization request to Nevada Medicaid.
NM	❖ The facility's composite rate reimbursement covers all dialysis services both in the facility and at home. Providers cannot bill separately for services included in this rate, as defined by Medicare, even though payments follow the Medicaid fee schedule.

<table>
<tr><td>OH</td><td>❖ Hemodialysis (HD) or Intermittent Peritoneal Dialysis (IPD) - one session per day, three sessions per week.
❖ Frequency limits may be exceeded if the medical necessity of added services is documented in the medical record by the practitioner responsible for the dialysis services.</td></tr>
<tr><td>SC</td><td>❖ PHYSICIANS ONLY: The monthly ESRD code covers all patient services for the month. Do not bill office visits separately from monthly supervision. Special procedures (e.g., shunt revision, cannula de-clotting) may also be billed separately.</td></tr>
<tr><td>TX</td><td>Renal dialysis facilities should not use HCPCS/CPT code when sending a claim with a revenue code.
❖ Renal dialysis facilities reimbursement is according to composite rates, which are based on the CMS specified calculations and the Texas Medicaid Reimbursement Methodology (TMRM). Texas Medicaid may reimburse for dialysis services by combined billing as defined by CMS.
❖ Only specific diagnosis codes can be billed for renal dialysis following acute kidney injury (AKI) or end-stage renal disease (ESRD). Any other diagnosis codes will result in claim denial. The applicable diagnosis codes are:
<table>
<tr><td>N17.0</td><td>N18.4</td></tr>
<tr><td>N17.1</td><td>N18.5</td></tr>
<tr><td>N17.2</td><td>N18.6</td></tr>
<tr><td>N17.8</td><td>N18.9</td></tr>
<tr><td>N17.9</td><td>N99.0</td></tr>
<tr><td>N18.1</td><td>T79.5XXA</td></tr>
<tr><td>N18.2</td><td>T79.5XXD</td></tr>
<tr><td>N18.30</td><td>T79.5XXS</td></tr>
<tr><td>N18.31</td><td></td></tr>
<tr><td>N18.32</td><td></td></tr>
</table>
❖ All services, except for ultrafiltration (revenue code B-881), are restricted to the diagnoses listed above.
❖ The composite rate includes all necessary equipment, supplies, and services for clients receiving dialysis, whether at home or at a facility. The facility's charge must exclude the physician's routine supervision fee.
❖ To receive composite rate payment, one of the following revenue codes must be billed.
<table>
<tr><td>821</td><td>3 per week</td></tr>
<tr><td>831</td><td>3 Per week</td></tr>
<tr><td>841</td><td>Hemodialysis equivalent session</td></tr>
<tr><td>851</td><td>Hemodialysis equivalent session</td></tr>
</table>
❖ DME ESRD supply (procedure code E1629 - Tablo for dialysis service) for necessary equipment, supplies, and services for clients receiving dialysis at home are excluded from the composite rate and will be paid separately.
❖ Most drugs and biologicals used for the treatment of ESRD or AKI is included in the composite rate payment and are not paid separately unless specified otherwise. The following drugs and biologicals used for the treatment of ESRD are excluded from the composite rate and will be paid separately:
<table>
<tr><td>J0879</td><td>J0882</td></tr>
<tr><td>J1439</td><td>J1756</td></tr>
<tr><td>J2916</td><td>Q4081</td></tr>
<tr><td>Q5105</td><td></td></tr>
</table>
❖ In addition to the diagnosis codes listed above, procedure code J0879 is restricted to diagnosis code L2989, and procedure code Q5105 is restricted to diagnosis code D631.</td></tr>
</table>

	❖ End Stage Renal Disease facilities offering dialysis treatments in-facility are compensated for up to three treatments per week. ESRD facilities treating patients at home, regardless of modality, receive payment for three hemodialysis equivalent treatments per week. ❖ Maintenance intermittent peritoneal dialysis (IPD) sessions typically last 10 to 12 hours and are performed three times per week. Occasionally, fewer sessions of longer duration may occur. Providers must send documentation of medical necessity if more than three sessions occur in one week. ❖ A combination of Hemodialysis (HD), Intermittent Peritoneal Dialysis (IPD), Continuous Ambulatory Peritoneal Dialysis (CAPD), and Continuous Cycling Peritoneal Dialysis (CCPD) treatments are limited to fourteen sessions within 31 days for any provider. If more than fourteen sessions are needed, providers must send documentation of medical necessity, such as medical records, physicians' notes, and lab results. Records must clearly justify the medical requirement for added sessions. ❖ Ultrafiltration is performed on a day separate from dialysis treatment. The dialysis facility must document in the medical record why the ultrafiltration could not have been performed during the dialysis treatment. Ultrafiltration performed on the same day as dialysis treatment is not reimbursed separately. Ultrafiltration may be reimbursed using revenue code 881 up to a maximum of three times per week.
UT	❖ Medicaid provides reimbursement for dialysis services using a composite rate. Services included in the composite rate are not eligible for separate reimbursement.
VA	❖ When dialysis centers use intradialytic parenteral nutrition (IDPN) during dialysis. Virginia Medicaid does not cover IDPN as amino acids, vitamins, minerals, or other nutrients given during dialysis. ❖ Dialysis centers enrolled in Virginia Medicaid must send charges for outpatient and home dialysis services and inform whether facility charges include the practitioner part.
WA	❖ Washington only recognizes CPT code 90999 for hemodialysis with revenue code 0821. Do not use codes 0831, 0841, or 0851. Limited to 14 sessions per client per month. ❖ Intermittent Peritoneal Dialysis (IPD), Outpatient/Home: Bill revenue code 0831. Limited to 14 sessions per client per month. ❖ Continuous Ambulatory Peritoneal Dialysis (CAPD), Outpatient/Home: Bill revenue code 0841. Do not combine with codes 0821, 0831, or 0851. Limited to 31 sessions per client per month. ❖ Continuous Cycling Peritoneal Dialysis (CCPD), Outpatient/Home: Bill revenue code 0851. Do not combine with codes 0821, 0831, or 0841. Limited to 31 sessions per client per month. ❖ Billing over 14 dialysis treatments per month is non-covered. Prior authorization is needed. Contact Washington Medicaid with EPA number 870001376 for approval. ❖ Non-covered services require documentation that links treatment to ESRD and approval from Washington Medicaid Kidney Disease Program Manager. All services must be supported by documentation proving medical necessity, including renal dialysis services. These are subject to retrospective review and recoupment if unsupported.

Documentation History

Type	Date	Action
Effective Date	04/26/2024	New Policy
Revised Date	12/16/2024	Updated templates
Revised Date	02/25/2025	Created a new policy by combining ESRD 90999 No Modifier (Weekly and Monthly) Limits with new policy on three days a week dialysis limitation.

Reference Documentation

Reference	Link
AAPC	New Modifier Captures Noncovered Hemodialysis - AAPC Knowledge Center

	Medical Coding Dialysis | Coding Clarified
CMS	Medicare Benefit Policy Manual – p. 33 Article - Billing and Coding: Frequency of Hemodialysis (A55723) Medicare Claims Processing Manual – p. 6
First Coast Service	End-stage renal disease (ESRD) billing requirements
Noridian	Condition Codes - JE Part A - Noridian Hemodialysis In-Facility or Home Setting - JE Part A - Noridian
Novita's	End stage renal disease billing requirements
AZ	FFS_Chap15Dialysis.pdf
KY	Chapter 63 (HJR 52)
MA	Commonwealth of Massachusetts
MI	MedicaidProviderManual.pdf
MS	Administrative Code
NE	Title 471, Chapter 18: Physicians' Services (2022)
NV	NV_BillingGuide_PT45
NM	8.325.2 NMAC
OH	5160-13-02_20210701.pdf
SC	Physician Services Provider Manual 09-01-2024
TX	TMPPM.book – pp. 17 - 28
UT	R414-19A. Coverage for Dialysis Services by an End Stage Renal Disease Facility, R414. Health, Health Care Financing, Coverage and Reimbursement Policy, Utah Administrative Code
VA	Chapter 4 Covered Services and Limitations (Renal Dialysis Clinic).pdf
WA	kdp-manual-20240101.pdf Kidney Center Services Billing Guide

CODING DISCLAIMER. *Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is given may not be eligible for reimbursement. Listing of a service or device code in this policy does guarantee coverage. Coverage is decided by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). The AMA copyrights all CPT codes and descriptions; this information is for informational purposes only. Providers and facilities are expected to use industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.*