MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid
Part 216
Dialysis Services

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Title 23: Division of Medicaid

Part 216: Dialysis Services

Part 216 Chapter 1: Dialysis Services

Rule 1.1: Provider Enrollment Requirements

Freestanding or hospital-based kidney dialysis centers must satisfy all requirements set forth in Miss. Admin. Code, Part 200, Chapter 4, Rule 4.8, in addition to the following provider type specific requirements:

A. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES),

B. Written confirmation from the IRS confirming the providers tax identification number and legal name, and

C. Copy of dialysis Medicare certification:

    1. Explanation of Medicare Benefits (EOMB) is not acceptable, and

    2. Must be from a Medicare Administrative Contractor.

Source: 42 CFR 455, Subpart E; Miss. Code Ann. § 43-13-121.

Rule 1.2: Covered Services

A. The Division of Medicaid covers:

    1. Hemodialysis,

    2. Peritoneal dialysis,

    3. Continuous Ambulatory Peritoneal Dialysis (CAPD), and

    4. Continuous Cyclic Peritoneal Dialysis (CCPD).

B. Prior authorization is not required for dialysis services.

C. The Division of Medicaid covers:

    1. All resources used in providing outpatient dialysis services, including supplies and equipment used to administer dialysis in the ESRD (end stage renal disease) facility or at a beneficiary's home, drugs, biologicals, laboratory tests, and support services under the bundled ESRD PPS (prospective payment system) rate,

2. Professional services,

3. Antibiotics, when used at home by a beneficiary, to treat an infection of the catheter site or peritonitis associated with peritoneal dialysis, and

4. Specified lab tests and injectable drugs not included in the bundled ESRD PPS rate, when medically necessary.

Source: 42 CFR 494; Miss. Code Ann. § 43-13-121.

History: Revised to correspond with SPA 14-003 (eff. 01/01/2014) eff. 05/01/2014.

Rule 1.3: Bundled ESRD PPS /Definition of Units

Effective July 1, 2021, the Division of Medicaid reimburses freestanding and hospital-based ESRD facilities the bundled ESRD PPS rate effective as of January 1, 2021 for all resources used in providing outpatient dialysis services, including supplies and equipment used to administer dialysis in the ESRD facility or at a beneficiary's home, drugs, biologicals, laboratory tests and support services.

1. The facility must furnish all necessary services, equipment, and supplies.

2. The appropriate revenue codes must be billed for the ESRD PPS rate.

3. Dialysis services are not reimbursed if there are no corresponding treatment notes.

The Division of Medicaid covers three (3) units of hemodialysis per a seven (7) day week.

1. Hemodialysis is typically furnished three (3) times per week in treatment sessions lasting four (4) to five (5) hours.

2. One (1) unit is equal to one (1) treatment session.

The Division of Medicaid covers one (1) unit for each day, up to thirty-one (31) days, per month for home hemodialysis, peritoneal dialysis, Continuous Ambulatory Peritoneal Dialysis (CAPD) and Continuous Cycling Peritoneal Dialysis (CCPD). The Division of Medicaid defines one (1) unit as one (1) twenty-four (24) hour day.

Medical documentation substantiating the medical necessity for additional units is required.

Source: 42 CFR 494; Miss. Code Ann. § 43-13-121.

History: Revised eff. 07/01/2021, Revised to correspond with SPA 14-003 (eff. 01/01/2014) eff. 05/01/2014.

Rule 1.4: Professional Services

A. The Division of Medicaid covers related physician services for ESRD billed with the appropriate procedure codes which are excluded from the ESRD PPS rate.

    1. The physician or qualified health care professional must provide one (1) face-to-face visit with the beneficiary monthly.

    2. The medical record must contain the physician or qualified health care professional's documentation substantiating the medical necessity for additional face-to-face visits.

    3. Documentation must be legibly written, signed and dated during the face-to-face visit.

    4. Documentation by the interdisciplinary team cannot substantiate the medical necessity of the physician or qualified health care professional's face-to-face visit.

B. Physician services are not covered under the facility's provider number.

C. Face-to-face physician visits are not included in the physician services visit limit.

D. Evaluation and management services provided to the beneficiary which are unrelated to dialysis services cannot be performed during the dialysis session and must be reported separately.

Source: 42 CFR § 414.310; Miss. Code Ann. § 43-13-121.

History: Revised to correspond with SPA 14-003 (eff. 01/01/2014) eff. 05/01/2014.

Rule 1.5: Documentation Requirements

A. Dialysis providers must maintain auditable records that substantiate the dialysis services provided.

B. The physician or qualified healthcare professional's documentation in the medical record must include, but not limited to, the following:

    1. Dates of service,

    2. Monthly face-to-face evaluation of the beneficiary's current health status, medical condition, provider findings and appropriateness of the treatment plan,

    3. Mode of dialysis and treatment plan,

    4. All treatments, medications, biologicals, lab tests and other studies both included and excluded in the ESRD PPS rate, and

5. A legible signature of the physician or qualified healthcare professional with documented credentials to support the service rendered and date of entry.

C. If more than one (1) face-to-face physician or qualified healthcare professional visit is required within a month the:

   1. Physician or qualified healthcare professional's documentation must support the medical necessity for the visit.

   2. Interdisciplinary team documentation cannot be used to substantiate billing a physician or qualified healthcare professional's face-to-face visit.

D. The dialysis facility's record must include, but not limited to, the following:

   1. Dates of service,

   2. Current annual evaluation including age and gender-appropriate history and physical examination documented by a physician including all pertinent lab and diagnostic procedures,

   3. Individualized treatment notes which must include documentation verifying each face-to-face physician visit,

   4. Beneficiary assessment in accordance with 42 CFR § 494.80,

   5. Mode of dialysis and treatment plan,

   6. All treatments, medications, biologicals, lab tests and other studies both included and excluded in the ESRD PPS rate,

   7. A written plan of care prepared and reviewed monthly by an interdisciplinary team that includes the beneficiary's physician and other healthcare professionals, as appropriate, familiar with the beneficiary's condition, and

   8. A legible signature of the physician or healthcare professional with documented credentials to support the service rendered and date of entry.

Source: Miss. Code Ann. § 43-13-121.

History: Revised to correspond with SPA 14-003 (eff. 01/01/2014) eff. 05/01/2014.

Rule 1.6: Immunizations

A. Medicaid reimburses dialysis facilities for influenza and pneumonia vaccines when provided by and administered by the dialysis facility to beneficiaries receiving dialysis services.

B. Influenza and pneumonia vaccines are excluded from the ESRD PPS rate.

Source: Miss. Code Ann. § 43-13-121.

History: Revised to correspond with SPA 14-003 (eff. 01/01/2014) eff. 05/01/2014.

Rule 1.7: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Miss. Admin. Code, Part 223, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121.