



Mississippi Medicaid  
Provider Reference Guide  
For Part 216  
Dialysis

*This is a companion document to the  
Mississippi Administrative Code Title 23  
and must be utilized as a reference only.*

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## Dialysis Introduction

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Medicaid, as authorized by Title XIX of the Social Security Act, is a federal and state program of medical assistance to qualified individuals. Each state designates a state agency as the single state agency for the administration of Medicaid. State law has designated the Division of Medicaid, Office of the Governor, as the single state agency to administer the Medicaid program in Mississippi.

Hemodialysis, Peritoneal Dialysis, Continuous Ambulatory Peritoneal Dialysis (CAPD), and Continuous Cyclic Peritoneal Dialysis (CCPD) are covered dialysis services.

Kidney dialysis services require no prior authorization. Freestanding or hospital based dialysis centers that sign a provider agreement with the DOM may be reimbursed for services provided to Medicaid beneficiaries.

A dialysis provider's participation in the Mississippi Medicaid program is entirely voluntary. However, if a provider does choose to participate in Medicaid, the provider must accept the Medicaid payment as payment in full for those services covered by Medicaid. The provider cannot charge the beneficiary the difference between the usual and customary charge and Medicaid's payment. The provider cannot accept payment from the beneficiary, bill Medicaid, and then rebate Medicaid's payment to the beneficiary. Services not covered under the Medicaid program can be billed directly to the Medicaid beneficiary.

The Mississippi Medicaid program purchases needed health care services for beneficiaries as determined under the provision of the Mississippi Medical Assistance Act. The Division of Medicaid (DOM) is responsible for formulating program policy. DOM staff is directly responsible for the administration of the program. Under the direction of DOM staff, the fiscal agent is responsible for processing claims, issuing payments to providers, and for notifications regarding billing. Medicaid Policy as it relates to these factors is initiated by DOM.

## Composite Rate Reimbursement/Definition of Units

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The composite rate reimbursement (CRR) is a comprehensive payment for all modes of treatment in the freestanding facility, renal dialysis unit (RDU) or home setting. It covers the complete treatment except for covered x-ray, lab, and injectable drugs that are separately billable and reimbursed on a fee schedule. The facility must furnish all necessary services, equipment and supplies. If the facility fails to do so, no payment will be made.

When billing the composite rate, the provider must submit a UB-04 along with the appropriate revenue code(s).

Note: Units in Form Locator 46 are required when billing renal dialysis revenue codes.

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**Revenue Codes**

- 821 – Hemodialysis – Outpatient or Home Composite or Other Rate
- 831 - Peritoneal Dialysis – Outpatient or Home Composite or Other Rate
- 841 - Continuous Ambulatory Peritoneal Dialysis (CAPD) – Outpatient or Home Composite or Other Rate
- 851 - Continuous Cycling Peritoneal Dialysis (CCPD) – Outpatient or Home Composite or Other Rate

REV CODE	TYPE	UNIT	ALLOWANCE FORMULA	MAX UNITS	BILLING INTERVALS
821	Hemodialysis Outpatient or Home	*One (1) unit is one treatment session	(1) Composite rate x total units	14	Monthly
831	Peritoneal Dialysis Outpatient or Home	*One (1) unit is one treatment session	(1) Composite rate x total units	14	Monthly
841	CAPD  Outpatient or Home	*One (1) unit is one day	(1) Composite rate x total units	14	Monthly
851	CCPD  Outpatient or Home	*One (1) unit is one day	(1) Composite rate x total units	14	Monthly

Note: Do not file more than three (3) units per seven (7) day week.

A paper claim must be submitted with medical documentation explaining the reason for additional units should units exceed the indicated maximums.

**Definition of Units****Hemodialysis**

Hemodialysis is typically furnished three times per week in sessions of 4 to 5 hours. A unit is one of the 4 to 5 sessions.

**Peritoneal Dialysis**

Peritoneal Dialysis in the facility may be done in the following treatment sessions:

- 10 - 12 hours = 3 times per week
- 20 - 29 hours = 2 times per week
- 30 & Above Hours = 1 time per week

Peritoneal Dialysis at home may be done in several different treatment sessions. The total weekly dialysis time varies typically from 50 to 80 hours. For example, home IPD may be furnished every day for 10 hours per day, every other day for 15 hours per dialysis day, every night for 8 hours per night, etc.

A unit is a treatment session.

**Continuous Ambulatory Peritoneal Dialysis (CAPD)**

Continuous Ambulatory Peritoneal Dialysis is furnished on a continuous (daily) basis. A unit is one day (24 hours).

**Continuous Cycling Peritoneal Dialysis (CCPD)**

Continuous Cycling Peritoneal Dialysis is furnished on a continuous (daily) basis. A unit is one day (24 hours).

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## Laboratory Tests and Injectable Drugs

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### Laboratory Tests and Injectable Drugs Included in the Composite Rate

The administration of these items (both the staff time and the supplies) is covered under the composite rate and may not be billed separately.

#### 1. Per treatment

All hematocrit, hemoglobin and clotting time tests furnished incident to dialysis treatments.

#### 2. Weekly

Serum Creatinine

Prothrombin time (PT) for patients on anticoagulant therapy

#### 3. Weekly or Thirteen (13) per quarter

Blood Urea Nitrogen (BUN)

#### 4. Monthly

Alkaline Phosphatase

Complete Blood Count (CBC)

Lactate Dehydrogenase (LDH)

Serum Albumin

Serum Bicarbonate

Serum Calcium

Serum Chloride

Serum Potassium

Total Protein

Serum Phosphorus

Serum Glutamic-Oxaloacetic Transaminase (SGOT)

#### 5. The following parenteral items cannot be billed separately:

Antiarrhythmics

Antihistamines

Antihypertensives

Apresoline (hydralazine)

Benadryl

Dextrose

Dopamine	Glucose
Heparin	Heparin Antidotes
Hydralazine	Inderal
Insulin	Lanoxin
Levophed	Lidocaine
Local Anesthetics	Mannitol
Pressor Drugs	Protamine
Saline	Solu-cortef
Verapamil	

Antibiotics (when used at home by a patient to treat an infection of the catheter site or peritonitis associated with peritoneal dialysis)

### Laboratory Tests and Injectable Drugs that May Be Billed Separately

The following list contains tests or injectable drugs that are billable in addition to the composite rate. When furnished at a greater frequency than specified below, they are only covered when medically justified as documented in the facility records.

1. Hepatitis B Vaccine - 3 (2 ml) doses  
First Dose  
Second Dose - 1 month after first dose  
Third Dose - 6 months after first dose

For Seronegative patients (including patients who have received Hepatitis B vaccine but did not have a positive response to the vaccine) - Hepatitis B Surface Antigen (HB Ag) - one (1) a month.

2. Hepatitis B Surface Antibody or Hepatitis B Core Antibody - one (1) (but not both) once a year
3. Bone Survey (either the roentgenographic method or the photon absorptiometric procedure for bone mineral analysis) - one (1) a year.
4. Darbepoetin alfa (Aranesp)
5. Epogen

6. Injectable Albumin\*
7. Injectable Anabolics
8. Injectable Analgesics
9. Injectable Antibiotics
10. Injectable Hematinics
11. Injectable Muscle Relaxants\*
12. Injectable Sedatives
13. Injectable Tranquilizers
14. Platelet Count- one (1) every three (3) months
15. Red Blood Count (RBC) - one (1) every three (3) months
16. Residual renal function- one (1) every six (6) months
17. Serum Aluminum - one (1) every three (3) months
18. Serum Ferritin - one (1) every three (3) months
19. Thrombolytics used to declot central venous catheters
20. White Blood Count (WBC) - one every three (3) months
21. 24 hour urine volume- one every six (6) months

\*When not used as a substitute for a drug covered in the composite rate. Staff time used to administer separately billable parenteral items is covered under the composite rate and may not be billed separately. If an automated battery of tests such as the SMA-12 is performed, and it contains most of the tests listed in one of the weekly or monthly categories above, it is not necessary to separately identify any tests in the battery that are not listed.

When any of these tests are performed at a greater frequency, the test may be billed separately and is covered when medically justified as documented in the facility records.

If there is no specific J-Code in the HCPCS list for a drug, it may be billed on a paper UB-04 claim using J3490. The name of the drug, the strength, and the dosage must be indicated, and one unit should be reported on the face of the claim. The drug may be covered if it is not experimental or investigative and it is being used according to recommended usage guidelines. The drug will be reviewed and manually priced.

Staff time used to administer separately billable parenteral items is covered under the composite rate and may not be billed separately.

## Documentation Requirements

All professional and institutional providers participating in the Medicaid program are required to maintain records that will disclose services rendered and billed under the program and, upon request, make such records available to representatives of DOM or Office of Attorney General in substantiation of any or all claims. These records should be retained a minimum of five (5) years in order to comply with all state and federal regulations and laws.

Providers must maintain proper and complete documentation to verify the services provided. The provider has full responsibility for maintaining documentation to justify the services provided.

DOM and/or the fiscal agent have the authority to request any patient records at any time to conduct a random sampling review and/or document any services billed by the dialysis provider.

If a dialysis provider's records do not substantiate services paid for under the Mississippi Medicaid program, as previously noted, the provider will be asked to refund to the Mississippi Medicaid program any money received from the program for such non-substantiated services. If a refund is not received within 30 days, a sum equal to the amount paid for such services will be deducted from any future payments that are deemed to be due the dialysis provider.

A dialysis provider who knowingly or willfully makes, or causes to be made, false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under federal and state criminal laws. A false attestation can result in civil monetary penalties as well as fines, and may automatically disqualify the dialysis provider as a provider of Medicaid Services.

## Dual Eligibles

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For kidney dialysis services covered by Medicare, Medicaid will pay the deductible and/or co-insurance. Mississippi Medicaid service limits are applicable unless otherwise specified by the Division of Medicaid.