Renal Dialysis

CSHCN Services Program Provider Manual

May 2025

TEXAS
Health and Human
Services

RENAL DIALYSIS

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35.1 Enrollment

To enroll in the CSHCN Services Program, renal dialysis facilities must be licensed by the state of Texas as an end-stage renal disease (ESRD) facility, and be certified by Medicare. Home health agencies must be licensed by the state of Texas as home and community support services agencies designated to provide home dialysis services. The facilities must be actively enrolled in Texas Medicaid, have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Out-of-state renal dialysis facility providers must meet all these conditions, and be located in the United States, within 50 miles of the Texas state border.

Important: *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in Title 1 of the TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

Refer to: Section 2.1, "Provider Enrollment" in Chapter 2, "Provider Enrollment and Responsibilities" for more detailed information about CSHCN Services Program provider enrollment procedures.

35.2 Client Eligibility

Clients needing renal dialysis must also apply for Medicare coverage, unless the referring provider attests that the client is not eligible for Medicare. If the client is not eligible for Medicare coverage, the CSHCN Services Program may reimburse dialysis services as long as the services are needed. CSHCN Services Program coverage of renal dialysis begins with the client's initial date of eligibility or the first dialysis treatment, whichever is later.

35.3 Benefits, Limitations, and Authorization Requirements

The following services are a benefit of renal dialysis centers billing under Reimbursement Methodology Consolidated Billing:

Revenue Codes - Hemodialysis

Revenue Code	Description
821	Hemodialysis (outpatient/home) - composite or other rate. Use for maintenance.
829	Hemodialysis (outpatient/home) - other. Use for training.

Revenue Codes - Intermittent Peritoneal Dialysis (IPD)

Revenue Code	Description
831	Peritoneal Dialysis (outpatient/home) - composite or other rate. Use for maintenance.
839	Peritoneal Dialysis (outpatient/home) - other. Use for training.

Revenue Codes - Continuous Cycling Peritoneal Dialysis (CCPD)

Revenue Code	Description
851	CCPD (outpatient/home) - composite or other rate. Use for maintenance.
859	CCPD (outpatient/home) - other. Use for training.

Revenue Codes - Ultrafiltration

Revenue Code	Description
881	Miscellaneous dialysis - ultrafiltration

The following physician services are a benefit for physician supervision of end-stage renal disease (ESRD) dialysis services and are restricted to chronic kidney disease stage 5 (diagnosis code N185) and ESRD (diagnosis code N186).

Procedure Codes - Physician Services for End-Stage Renal Dialysis

Procedure Codes									
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960
90961	90962	90963	90964	90965	90966	90967	90968	90969	90970

Physician Services for Hemodialysis or Other Dialysis Procedures

Procedure Codes									
90935	90937	90945	90947						

Physician supervision of outpatient ESRD dialysis includes services rendered by the attending physician during office visits where any of the following occur:

- Routine monitoring of dialysis
- Treatment or follow-up of complications of dialysis, including:
  - Evaluation of related diagnostic tests and procedures
  - Services involved in prescribing therapy for illnesses unrelated to renal disease, if the treatment occurs without increasing the number of physician-contact contracts

All physician, renal dialysis center, and medical supplier supporting documentation is subject to retrospective review.

Renal dialysis services must be submitted with the most appropriate diagnosis code from the following table:

Diagnosis Codes							
N170	N171	N172	N178	N179	N181	N182	N1830
N1831	N1832	N184	N185	N186	N189	N990	T795XXA
T795XXD	T795XXS						

Note: *All services, except ultrafiltration (revenue code 881), are diagnosis restricted as listed in the above table.*

Procedure code G0257 may be reimbursed for services rendered to clients with stage V chronic kidney disease (diagnosis code N185) and end-stage renal disease (ESRD) (diagnosis code N186).

The following additional services related to renal dialysis are benefits of the CSHCN Services Program:

- Ultrafiltration
- Dialysis training not to exceed 18 days of hemodialysis or peritoneal (IPD, CAPD, or CCPD) training

  Note: *The facility charge for dialysis services is denied as part of the dialysis training when billed with the same date of service as the dialysis training.*
- Related physician services
- Dialysis support services

The installation and repair of home hemodialysis machines is not a benefit. Home modifications for use of medical equipment are not a benefit.

35.3.1 Renal Dialysis Facilities - Consolidated Billing

Outpatient dialysis is furnished on an outpatient basis at a renal dialysis center or facility.

Allowable outpatient dialysis services include:

- Staff-assisted dialysis performed by the center's or facility's staff.
- Self-dialysis performed by a client with little or no professional assistance, provided that the client has completed an appropriate course of training.
- In-home dialysis performed by an appropriately trained client or an appropriately trained caregiver.
- Dialysis services provided in an approved renal dialysis facility on an outpatient basis.

Renal dialysis facilities are reimbursed according to composite rates, which are based on CMS-specified calculations and the Texas Medicaid Reimbursement Methodology (TMRM).

The facility bills an amount that represents the charge for the facility's service to the dialysis client. The facility's charge must not include the charge for the physician's routine supervision.

A revenue code (821, 831, 841, or 851) must be billed for the dialysis facility to receive the composite rate payment.

35.3.1.1 Maintenance Hemodialysis

ESRD facilities furnishing dialysis treatments in-facility are paid 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.

35.3.1.2 Maintenance IPD

Maintenance intermittent peritoneal dialysis (IPD) is usually performed in sessions of 10 to 12 hours duration, three times per week. However, it is sometimes performed in fewer sessions of longer duration.

35.3.1.3 Maintenance CAPD and CCPD

For clients undergoing CAPD or CCPD in the home, the number of days of peritoneal dialysis regardless of dialysate exchanges performed each day will be 14 per 31 days.

A combination of HD, IPD, CAPD, CCPD dialysis treatments are limited to 14 sessions within 31 days for any provider. If more than 14 sessions are needed, the provider must supply documentation of medical necessity with the claim. Documentation can include but is not limited to medical records, physicians' notes, and lab results. Records must clearly show why extra sessions are medically required.

The ordering physician must maintain documentation supporting medical necessity in the client's medical record.

The composite rate includes all necessary equipment, supplies, and services for the client receiving dialysis whether in the home or in a facility. The following procedure codes are for ESRD DME supplies:

Procedure Codes									
36000	36430	36591	36593	49421	71045	71046	71047	71048	93005
93040	93041	A4215	A4216	A4217	A4218	A4244	A4245	A4246	A4247
A4248	A4450	A4452	A4651	A4652	A4653	A4657	A4660	A4663	A4670
A4671	A4672	A4673	A4674	A4680	A4690	A4706	A4707	A4708	A4709
A4714	A4719	A4720	A4721	A4722	A4723	A4724	A4725	A4726	A4728
A4730	A4736	A4737	A4740	A4750	A4755	A4760	A4765	A4766	A4770
A4771	A4772	A4773	A4774	A4802	A4860	A4870	A4890	A4911	A4913
A4918	A4927	A4928	A4929	A4930	A4931	A4932	A6204	A6215	A6216
A6250	A6260	A6402	E0210	E0424	E0431	E0434	E0439	E0440	E0441
E0442	E0443	E0444	E0447	E1500	E1510	E1520	E1530	E1540	E1550
E1560	E1570	E1575	E1580	E1590	E1592	E1594	E1600	E1610	E1615
E1620	E1625	E1630	E1632	E1634	E1635	E1636	E1637	E1639	E1699

Procedure codes for equipment and supplies listed in the above DME ESRD Supply HCPCS table are included in the composite rate and are not reimbursed separately.

The Tablo hemodialysis system procedure code (E1629) is excluded from the composite rate and will be paid separately for clients receiving services within the home.

Providers must use procedure code E1629 with revenue code 821.

Laboratory testing may be obtained and processed in the renal dialysis facility or by an outside laboratory. Charges for the following routine laboratory tests are included in the facility's composite rate billed to Medicaid regardless of where tests were processed. Routine laboratory testing processed by an outside laboratory are billed to the facility and billed by the renal dialysis facility unless they are inclusive tests.

The following procedure codes are for labs subjected to ESRD consolidated billing:

Procedure Codes									
80047^	80048^	80051^	80053^	80069^	80076	81050	82040^	82108	82306
^ QW Modifier									

Procedure Codes									
82310^	82330^	82374^	82379	82435^	82565^	82570^	82575	82607	82610
82652	82668	82728	82746	82947	83540	83550	83615	83735	83970
84075^	84100	84132^	84134	84155^	84157	84295^	84450	84466	84520^
84540	84545	85004	85014^	85018^	85025^	85027	85041	85044	85045
85046	85048	85345	85347	85610^	86704	86705	86706	87040	87070
87071	87073	87075	87076	87077	87081	87340	87341	87467	G0306
G0307	G0499								
^ QW Modifier									

Routine laboratory services listed in the procedure codes table for labs subject to ESRD consolidated billing are included in the composite rate and are not reimbursed separately.

All drugs and biologicals used for the treatment of ESRD or acute kidney injury (AKI) (unless specified otherwise) are included in the composite rate payment and are not paid separately. This includes the following drugs, which are subjected to ESRD consolidated billing:

Procedure Codes									
J0360	J0604	J0606	J0620	J0630	J0636	J0670	J0878	J0884	J0887
J0892	J0895	J0899	J0945	J1160	J1200	J1205	J1240	J1265	J1270
J1443	J1444	J1445	J1642	J1643	J1644	J1720	J1740	J1750	J1800
J1940	J1945	J1955	J2150	J2360	J2430	J2501	J2720	J2795	J2993
J2997	J3265	J3364	J3365	J3370	J3410	J3420	J3480	J3489	J7030
J7040	J7042	J7050	J7060	J7070	J7120	J7131	Q0163	Q5105	

Procedure codes for labs or drugs subjected to ESRD consolidated billing will deny if submitted with procedure code G0257 or the following revenue codes:

Revenue Codes								
821	829	831	839	841	849	851	859	880

The following drugs used for the treatment of ESRD are excluded from the composite rate and will be paid separately:

Procedure Codes				
J0882	J1439	J1756	J2916	Q4081

Other drugs and biologicals furnished by an ESRD facility that are not used for the treatment of ESRD may be billed separately.

The ordering physician must maintain documentation supporting medical necessity in the client's medical record.

35.3.2 Maintenance Hemodialysis

35.3.2.1 Training for Hemodialysis, IPD, CCPD, and CAPD

Most self-dialysis training for hemodialysis, IPD, CCPD, and CAPD is provided in an outpatient setting. Dialysis training provided in an inpatient setting will be reimbursed at the same rate as the facility's outpatient training rate.

Reimbursement for hemodialysis, IPD, CCPD, and CAPD training services and supplies provided by the dialysis facility include personnel services, parenteral items routinely used in dialysis, training manuals and materials, and routine dialysis laboratory tests. It may be necessary to supplement the patient's dialysis CAPD training with intermittent peritoneal dialysis or hemodialysis because the client has not mastered the CAPD technique.

Training is limited to once per day. The composite rate will be denied as part of dialysis training when billed for the same date of service.

The following revenue codes may be reimbursed for dialysis training:

Revenue Code	Procedure Description	Limitations
829	Hemodialysis (outpatient/home) - other. Use for training.	18 sessions per lifetime
839	Peritoneal Dialysis (outpatient/ home) - other. Use for training.	18 sessions per lifetime
849	CAPD (outpatient/home) - other. Use for training.	18 sessions per lifetime
859	CCPD (outpatient/home) - other. Use for training.	18 sessions per lifetime

35.3.3 Ultrafiltration

A separate ultrafiltration treatment to remove the excess fluid may be covered.

Ultrafiltration is performed on a day other than the day of a dialysis treatment. The dialysis facility must document in the medical record why the ultrafiltration could not have been performed at the time of dialysis treatment. Ultrafiltration performed on the same day as the dialysis treatment is not separately reimbursed.

Ultrafiltration may be reimbursed using revenue code 881 up to a maximum of 3 times per week:

Revenue Code	Procedure Description	Limitations
881	Miscellaneous dialysis - ultrafiltration	3 per week

Providers can request extra ultrafiltration procedures if they provide attachments that state any of the following:

- Fluid overload (E8771) or diagnosis codes (E8770, E8779, E878) are provided on claim.
- Clotted IV access.
- CRD treatment performed on another day due to holiday.
- Or other reasons why extra ultrafiltration is necessary.

35.3.4 Home Dialysis Items and Services

Texas Medicaid utilizes Medicare's composite rate reimbursement system, Consolidated Billing. Under this reimbursement system, the dialysis facility must assume responsibility for providing all home dialysis equipment, supplies, and home support services.

One of the following revenue codes must be billed for the dialysis facility to receive the composite rate payment for clients being treated in the home:

Revenue Code	Procedure Description	Limitations
821	Hemodialysis (HD) (outpatient/ home) - composite or other rate. Use for maintenance.	3 per week
831	Peritoneal Dialysis (outpatient/ home) - composite or other rate. Use for maintenance.	3 per week
841	CAPD (outpatient/home) - composite or other rate. Use for maintenance.	HD - equivalent sessions
851	CCPD (outpatient/home) - composite or other rate. Use for maintenance.	HD - equivalent sessions

Support services are included in the composite rate. Support services that are specifically applicable to home clients include, but are not limited to:

- Periodic monitoring of a client with a qualified social worker and a qualified dietitian, made in accordance with a plan prepared and periodically reviewed by a professional team, which includes the physician.
- Visits by trained personnel for the client with a qualified social worker and a qualified dietician, made in accordance with a plan prepared and periodically reviewed by a professional team, which includes the physician.
- Client's unscheduled visits to a facility made on an as-needed basis (e.g., assistance with difficult access situations).
- ESRD related laboratory tests covered under the composite rate.
- Providing, installing, repairing, testing, and maintaining home dialysis equipment, including appropriate water testing and treatment.
- Ordering of supplies on an ongoing basis.
- A record keeping system that assures continuity of care.
- Support services specifically applicable to CAPD also include but are not limited to the following:
    - Changing connecting tube/administration set.
    - Watching the client perform CAPD and assuring that is it done correctly and reviewing for the client any aspects of the technique they may have forgotten or informing the client of modifications in apparatus or technique.
    - Documenting whether the client has or has had peritonitis that requires physician intervention or hospitalization (unless there is evidence of peritonitis, a culture for peritonitis is not necessary).
    - Inspection of the catheter site.

35.3.5 Unscheduled or Emergency Dialysis in a Non-Certified ESRD Facility

The CSHCN Services Program will reimburse an unscheduled or emergency dialysis treatment furnished to ESRD clients in the outpatient department of a hospital that does not have a certified ESRD facility.

Reimbursement for procedure code G0257 is limited to the same services included in the composite. Providers will not be reimbursed for individual services related to dialysis. (Refer to Appendix for list of bundled services).

Reimbursement of other outpatient hospital services are only reimbursed when medically necessary and when they are not related to an unscheduled or emergency dialysis services. Providers must submit documentation of unrelated services.

Repeated billing of this service by the same provider for the same clients may indicate routine dialysis treatments are being performed and providers will be subject to recoupment upon medical record review.

Procedure code G0257 is limited to one service a day, any provider.

Procedure code G0257 must be billed with revenue code 880 on the same claim. If procedure code G0257 is not on the same claim as revenue code 880, it will be denied.

Erythropoietin (procedure code Q4081) may be billed separately and must be billed with revenue code 634 or 635 on the same claim.

Procedure code Q4081 is limited to three injections per calendar week (Sunday through Saturday).

Use the following procedure codes when billing for physician supervision of outpatient ESRD dialysis services:

Procedure Codes									
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960
90961	90962	90963	90964	90965	90966	90967	90968	90969	90970

In the circumstances where the client not on home dialysis has had a complete assessment visit during the calendar month and a full month of ESRD-related services are provided, the following procedure codes must be used:

Procedure Codes									
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960
90961	90962								

Note: *The procedure code will be determined by the number of face-to-face visits the physician has had with the client during the month, and the client's age.*

When a full calendar month of ESRD-related services are reported for clients on home dialysis, the appropriate procedure code (90963, 90964, 90965, or 90966) must be used.

Report procedure codes 90967, 90968, 90969, and 90970 when ESRD-related services are provided for less than a full month, per day, under the following conditions:

- Partial month during which the client, not on home dialysis, received one or more face-to-face visits but did not receive a complete assessment.
- Client on home dialysis received less than a full month of services.
- Transient client.
- Client was hospitalized during a month of services before a complete assessment could be performed.
- Dialysis was stopped due to recovery or death of client.
- Client received a kidney transplant.

Procedure codes 90967, 90968, 90969, and 90970 are limited to one per day by any provider. When billing procedure code 90967, 90968, 90969, or 90970, the dates of service must indicate each day that supervision was provided.

Procedure codes 90967, 90968, 90969, and 90970 will be denied when billed during the same calendar month by any provider as one of the following procedure codes, which are limited to once per month, any provider:

Procedure Codes									
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960
90961	90962	90963	90964	90965	90966				

The following services may be provided in conjunction with physician supervision of outpatient ESRD dialysis but are considered nonroutine and may be billed separately:

- Declotting of shunts when performed by the physician.
- Dialysis at an outpatient facility other than the usual dialysis setting for a client of a physician who bills the Monthly Capitated Payment (MCP). The physician must bill procedure code 90967, 90968, 90969, or 90970 for each date supervision is provided. The physician may not bill for the days that the client dialyzed elsewhere.
- Physician services beyond those that are related to the treatment of the client's renal condition that causes the number of physician-client contacts to increase. Physicians may bill on a fee-for-service basis if they supply documentation on the claim that the illness is not related to the renal condition and that additional visits are required.
- Physician services to inpatients.

If a client is hospitalized during a calendar month of ESRD related services before a complete assessment is performed, or the client receives one or more face-to-face assessments, but the timing of inpatient admission prevents the client from receiving a complete assessment, the physician should bill procedure code 90967, 90968, 90969, or 90970 for each date of outpatient supervision and bill the appropriate hospital evaluation and management code for individual services provided on the hospitalized days.

If a client has a complete assessment during a month in which the client is hospitalized, one of the following procedure codes must be reported for the month of supervision, determined by the number of face-to-face physician visits with the client during the month and the client's age:

Procedure Codes									
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960
90961	90962								

Note: *The appropriate inpatient evaluation and management codes should be reported for procedures provided during the hospitalization.*

Procedure codes 90935, 90937, 90945, and 90947 may be reimbursed as follows:

- Inpatient dialysis services for ESRD or non-ESRD clients when the physician is present during dialysis treatment. The physician must be physically present and involved during the course of the dialysis procedure. These codes are not payable for a cursory visit by the physician; hospital visit procedure codes must be used for a cursory visit.
    - The procedure codes are per day procedure codes and include complete care of the client; hospital visits cannot be billed on the same day as these codes.

    - If the physician only sees the client when they are not dialyzing, the physician should bill the appropriate hospital visit procedure code. The inpatient dialysis procedure code should not be submitted for payment.
- Outpatient dialysis services for non-ESRD clients.

Inpatient services provided to hospitalized clients for whom the physician has agreed to bill monthly may be reimbursed in one of the following three ways:

- The physician may elect to continue monthly billing, in which case she or he may not bill for individual services provided to the hospitalized clients.
- The physician may reduce the monthly bill by 1/30th for each day of hospitalization and charge fees for individual services provided on the hospitalized days.
- The physician may bill for inpatient dialysis services using the inpatient dialysis procedure codes. The physician must be present and involved with the clients during the course of the dialysis procedure.

Clients may receive dialysis at an outpatient facility other than his or her usual dialysis setting, even if their physician bills for monthly dialysis coordination. The physician must reduce the monthly billed amount by 1/30th for each day the clients is dialyzed elsewhere.

Physician services beyond those related to the treatment of the client's renal condition may be reimbursed on a fee-for-service basis. The physician should provide documentation stating the illness is not related to the renal condition and added visits are required.

Payment is made for physician training services in addition to the MCP for physician supervision rendered to maintenance facility clients.

35.3.6 Ultrafiltration

Ultrafiltration of the client's blood is part of a hemodialysis treatment and is included in the reimbursement for the hemodialysis treatment. Ultrafiltration is not a substitute for dialysis.

Medical complications may occur if the client retains excess fluid following a regular dialysis treatment. When an additional treatment is required to remove the excess fluid, the facility must provide documentation indicating the medical necessity of this additional treatment and must submit the claim for the ultrafiltration procedure using revenue code 881.

35.3.7 Evaluation and Management

Physician evaluation procedure codes 90935, 90937, 90945, and 90947 are a benefit in an inpatient setting for ERSD or non-ERSD services only when provided by a physician. The physician must be physically present and involved during the course of the dialysis.

Procedure codes 90935, 90937, 90945, and 90947 are also a benefit in an office or outpatient setting for non-ESRD services that are provided by a physician, physician assistant, or advanced practice registered nurse (APRN).

Only one evaluation procedure code may be reimbursed per day for any provider, regardless of setting. Hospital visits cannot be billed for the same date of service as an evaluation code.

If the physician only sees the patient when they are not dialyzing, the physician should bill the appropriate hospital visit procedure code. The inpatient dialysis procedure code should not be submitted for payment.

Outpatient dialysis services for non-ESRD clients may be reimbursed with procedure codes 90935, 90937, 90945, and 90947.

Reimbursement for physician supervision of outpatient ESRD dialysis includes services provided by the attending physician in the course of office visits where any of the following occur:

- The routine monitoring of dialysis
- The treatment or follow-up of complications of dialysis, including:
  - The evaluation of related diagnostic tests and procedures
  - Services involved in prescribing therapy for illnesses unrelated to renal disease, if the treatment occurs without increasing the number of physician-client contacts

The following procedure codes may be reimbursed for physician supervision of ESRD dialysis services:

Procedure Codes									
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960
90961	90962	90963	90964	90965	90966	90967	90969	90970	

In circumstances where the client is not on home dialysis, has had a complete assessment visit during the calendar month, and a full month of ESRD-related services are provided, one of the following procedure codes must be used:

Procedure Codes									
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960
90961	90962								

The procedure code will be determined by the number of face-to-face visits the physician has had with the client during the month and by the client's age.

When a full calendar month of ESRD-related services are reported for clients on home dialysis, procedure code 90963, 90964, 90965, or 90966 must be used. The appropriate procedure code will be determined by the client's age.

Procedure codes 90967, 90968, 90969, or 90970 should be billed per day when ESRD-related services are provided for less than a full month under the following conditions:

- Partial month during which the client, not on home dialysis, received one or more face-to-face visits but did not receive a complete assessment
- Client on home dialysis received less than a full month of services
- Transient client
- Client was hospitalized during a month of services before a complete assessment could be performed
- Dialysis was stopped due to recovery or death of client
- Client received a kidney transplant

Procedure codes 90967, 90968, 90969, and 90970 are limited to one per day by any provider. When billing these procedure codes, the dates of service must indicate each day that supervision was provided.

Procedure codes 90967, 90968, 90969, and 90970 will be denied when billed during the same calendar month by any provider as the procedure codes in the following table. Only one of the procedure codes in the following table will be reimbursed per calendar month to any provider:

Procedure Codes									
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960

Procedure Codes					
90961	90962	90963	90964	90965	90966

Physician services beyond those that are related to the treatment of the client's renal condition that cause the number of physician-client contacts to increase are considered nonroutine, and may be separately reimbursed. Physicians may bill on a fee-for-service basis if they supply documentation on the claim that the illness is not related to the renal condition and that additional visits are required.

35.3.8 Renal Transplants

Renal transplants are a benefit of the CSHCN Services Program with documentation of end-stage renal disease (ESRD).

Refer to: Section 24.3.1.5, "Renal (Kidney) Transplants" in Chapter 24, "Hospital" and Section 31.2.42.1, "Renal (Kidney) Transplant" in Chapter 31, "Physician" for detailed information about renal transplants.

35.3.9 Prior Authorization Requirements

Authorization is not required for renal dialysis services.

35.4 Claims Information

Renal dialysis facilities must submit claims to TMHP in an approved electronic format or on the UB-04 CMS-1450 paper claim form. Claims for separately billable drugs and laboratory fees must be submitted to TMHP in an approved electronic format or on the appropriate paper claim form. Hospitals and renal dialysis facilities must use the UB-04 CMS-1450 paper claim form and may include these separately billable items on the same UB-04 CMS-1450 form as the dialysis services. Physicians must use the CMS-1500 paper claim form. Providers may purchase both claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing claim forms, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Home health DME providers must use benefit code DM3 on all claims and authorization requests. All other providers must use benefit code CSN on all claims and authorization requests.

The HCPCS/CPT codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

Refer to: Chapter 41, "TMHP Electronic Data Interchange (EDI)" for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for general information about claims filing.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" and Section 5.7.2.7, "Instructions for Completing the UB-04 CMS-1450 Paper Claim Form" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

35.5 Reimbursement

The CSHCN Services Program may reimburse dialysis services using one of the following methods as defined by CMS:

- **Method I:** *Composite Rate.* The composite rate is paid to the dialysis facility as a comprehensive payment for all in-facility and Method I home dialysis. The cost of an item or service is included in this rate unless specifically excluded as separately billable. Separately billable services would include the physician's professional services, lab work that is designated as separately billable, and drugs that are designated as separately billable. The reimbursement rates associated with revenue codes (composite rates) are available in the Static Fee Schedules, Renal Dialysis Facility Insert, on the TMHP website at www.tmhp.com. CSHCN providers are reimbursed at the same rate as Medicaid providers.

Refer to: Section 35.3.1, "Renal Dialysis Facilities - Consolidated Billing" in this chapter for benefits and limitations concerning Method I billing.

- **Method II:** *Direct Dealing.* With direct dealing, the client works with a single supplier such as a durable medical equipment (DME) or other medical supplier (not a dialysis facility) to obtain supplies and equipment to dialyze at home. The supplier will bill the CSHCN Services Program for the services provided. Reimbursement for supplies and services is limited to a maximum amount of $1,974.45 per client, per calendar year.

Refer to: Section , "" in this chapter for benefits and limitations concerning Method II billing.

Physicians, laboratories, and medical suppliers may be reimbursed for renal dialysis services the lower of the billed amount or the amount allowed by Texas Medicaid.

Outpatient hospitals may be reimbursed for renal dialysis services at 72 percent of the billed amount multiplied by the hospital's Medicaid interim rate.

Advanced practice registered nurses (APRNs) and physician assistants may be reimbursed for renal dialysis services the lower of the billed amount or 92 percent of the amount allowed by Texas Medicaid for the same service provided by a physician.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at www.tmhp.com.

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled "Adjusted Fee" to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates/rate-changes.

Note: *Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

35.6 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.