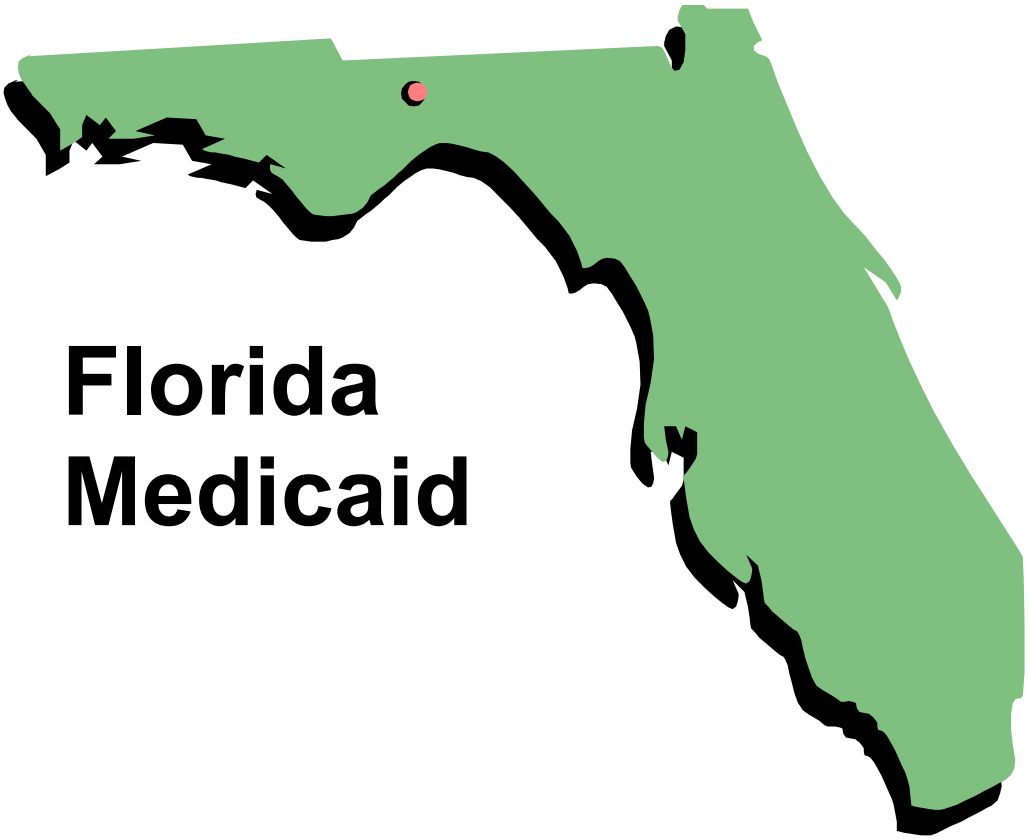

Florida Medicaid

Dialysis Services Coverage Policy

Agency for Health Care Administration

June 2025

Incorporated by reference in Rule 59G-4.105, F.A.C.

Table of Contents

1.0 Introduction

Dialysis is a life-support treatment that filters harmful wastes, salt, and excess fluid from an individual's blood. Dialysis services replace the functioning of the kidney and maintain the function of related organs that are compromised as a result of end stage renal disease.

1.1 Florida Medicaid Policies

This policy is intended for use by providers that render dialysis services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid's General Policies as defined in section 1.4 and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C). Coverage policies are available on the Agency for Health Care Administration's (AHCA) website at http://ahca.myflorida.com/Medicaid/review/index.shtml.

1.2 Statewide Medicaid Managed Care Plans

Florida Medicaid managed care plans must comply with the service coverage requirements outlined in this policy, unless otherwise specified in the AHCA contract with the Florida Medicaid managed care plan. The provision of services to recipients enrolled in a Florida Medicaid managed care plan must not be subject to more stringent service coverage limits than specified in Florida Medicaid policies.

1.3 Legal Authority

Dialysis services are authorized by the following:

- Title 42, Code of Federal Regulations (CFR), Part 494
- Section 409.906(9), Florida Statutes (F.S.)

1.4 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid Definitions Policy.

1.4.1 Claim Reimbursement Policy

A policy document found in Rule Division 59G, F.A.C., that provides instructions on how to bill for services.

1.4.2 Coverage and Limitations Handbook or Coverage Policy

A policy document found in Rule Division 59G, F.A.C., that contains coverage information about a Florida Medicaid service.

1.4.3 Composite Fee for Dialysis Treatment

Bundled payment for dialysis services including related supplies, laboratory tests, and services. These are the same services included in the Medicare composite rate.

1.4.4 Erythropoietin

An injectable medication that is a copy of a naturally occurring hormone produced primarily by healthy kidneys (also referred to as EPO and Epogen).

1.4.5 Freestanding Dialysis Center

A facility that provides chronic maintenance dialysis services to individuals with end stage renal disease and acute kidney injury on an outpatient basis.

1.4.6 General Policies

A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1, F.A.C., containing information that applies to all providers (unless otherwise specified) rendering services to recipients.

1.4.7 Hemodialysis
A process by which blood passes through an artificial kidney machine and the waste products diffuse across a manmade membrane into a bath solution known as dialysate, after which the cleansed blood is returned to the patient's body.

1.4.8 Medically Necessary/Medical Necessity
As defined in Rule 59G-1.010, F.A.C.

1.4.9 Peritoneal Dialysis
A process by which waste products pass from the patient's body through the peritoneal membrane into the peritoneal (abdominal) cavity where the bath solution (dialysate) is introduced and removed periodically.

1.4.10 Provider
The term used to describe any entity, facility, person, or group enrolled with AHCA to furnish services under the Florida Medicaid program in accordance with the provider agreement.

1.4.11 Recipient
For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

2.0 Eligible Recipient

2.1 General Criteria
An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy.

Provider(s) must verify each recipient's eligibility each time a service is rendered.

2.2 Who Can Receive
Florida Medicaid recipients requiring medically necessary dialysis services. Some services may be subject to additional coverage criteria as specified in section 4.0.

2.3 Coinsurance, Copayment, or Deductible
There is no copayment for this service in accordance with section 409.9081, F.S. For more information on copayment and coinsurance requirements and exemptions, please refer to Florida Medicaid's Copayments and Coinsurance Policy.

3.0 Eligible Provider

3.1 General Criteria
Providers must meet the qualifications specified in this policy in order to be reimbursed for Florida Medicaid dialysis services.

3.2 Who Can Provide
Services must be rendered by facilities certified by the Centers for Medicare and Medicaid Services (CMS) in accordance with 42 CFR 494.

4.0 Coverage Information

4.1 General Criteria
Florida Medicaid covers services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

4.2 Specific Criteria

Florida Medicaid covers the following in accordance with the applicable Florida Medicaid fee schedule, incorporated by reference in Rule 59G-4.002, F.A.C., Provider Reimbursement Schedules and Billing Codes, or as specified in this policy:

4.2.1 Dialysis Treatment

- Hemodialysis treatments provided at a hospital or freestanding dialysis center
- Peritoneal dialysis treatments provided at a hospital or freestanding dialysis center
  - When treatment is provided by a freestanding dialysis center, the treatment may be provided at the freestanding dialysis center or the recipient's home.

Florida Medicaid covers dialysis treatment via composite fee which includes:

- All supervision and management of the dialysis treatment routine
- Durable and disposable medical supplies
- Equipment
- Laboratory tests
- Support services
- Parenteral drugs and applicable drug categories (including substitutions)
- Training and monitoring for recipients receiving peritoneal dialysis treatment

4.2.2 Erythropoietin Stimulating Agents

Florida Medicaid covers erythropoiesis stimulating agents in accordance with Rule 59G-4.002, F.A.C.

4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's Authorization Requirements Policy.

5.0 Exclusion

5.1 General Non-Covered Criteria

Services related to this policy are not covered when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider's service

5.2 Specific Non-Covered Criteria

Florida Medicaid does not cover self-administered erythropoietin.

6.0 Documentation

6.1 General Criteria

For information on general documentation requirements, please refer to Florida Medicaid's Recordkeeping and Documentation Requirements Policy.

6.2 Specific Criteria

There is no coverage-specific documentation requirement for this service.

7.0 Authorization

7.1 General Criteria
The authorization information described below is applicable to the fee-for-service delivery system. For more information on general authorization requirements, please refer to Florida Medicaid's Authorization Requirements Policy.

7.2 Specific Criteria
There are no specific authorization criteria for this service.

8.0 Reimbursement

8.1 General Criteria
The reimbursement information below is applicable to the fee-for-service delivery system.

8.2 Specific Criteria
Providers submitting pharmaceutical claims for injectable medications must include National Drug Codes (NDC) to permit invoicing for federal or state supplemental rebates from manufacturers.

Claims for drug products that do not include NDC information are not covered unless the drug product is exempt from federal rebate requirements.

8.3 Claim Type
Institutional (837I/UB-04)

8.4 Billing Code, Modifier, and Billing Unit
Providers must report the most current and appropriate billing code(s), modifier(s), and billing unit(s) for the service rendered, incorporated by reference in Rule 59G-4.002, F.A.C.

Claims for erythropoietin do not require modifiers.

8.5 Diagnosis Code
Providers must report the most current and appropriate diagnosis code to the highest level of specificity that supports medical necessity, as appropriate for this service.

Providers must include diagnosis code N18.6 on all claims for dialysis services rendered to individuals with end stage renal disease.

8.6 Rate
For a schedule of rates, incorporated by reference in Rule 59G-4.002, F.A.C., visit the AHCA website at http://ahca.myflorida.com/Medicaid/review/index.shtml.