Ohio Administrative Code

Rule 5160-13-02 Dialysis services rendered by a dialysis center.

Effective: July 1, 2021

(A) Coverage and limitations.

(1) Payment may be made for dialysis performed for the treatment of kidney dysfunction resulting from conditions such as end-stage renal disease (ESRD) or acute kidney injury (AKI).

(2) If an individual is eligible for both medicare and medicaid, then coverage by medicaid as the primary payer continues only until medicare coverage begins.

(3) Payment may be made for hemodialysis (HD) or for any of three types of peritoneal dialysis: intermittent peritoneal dialysis (IPD), continuous ambulatory peritoneal dialysis (CAPD), or continuous cycling peritoneal dialysis (CCPD).

(4) Dialysis self-care training is instruction of the individual or a caregiver on how to perform self-dialysis with little or no professional assistance. It is customarily provided in conjunction with a session of dialysis treatment.

(5) The following frequency limits apply:

(a) HD or IPD - one session per day, three sessions per week;

(b) CAPD or CCPD (normally performed in a setting other than a dialysis center) - one session per day, seven sessions per week;

(c) HD self-care training - a total of twenty-five sessions to be conducted within a period not to exceed ninety-one days;

(d) IPD self-care training - a total of twelve sessions to be conducted within a period not to exceed twenty-eight days; and

(e) CAPD or CCPD self-care training - a total of fifteen sessions.

(6) Frequency limits may be exceeded only if the medical necessity of the additional service is documented in the medical record by the practitioner who is primarily responsible for the dialysis services.

(B) Payment.

(1) Medicaid payment for a covered dialysis service rendered by a dialysis center is made as a per-visit payment amount (PVPA). This medicaid PVPA includes all applicable related services, tests, equipment, supplies, and incidental instruction furnished on the same date. A list of these related items, designated by medicare as items that are "subject to consolidated billing," is published by the centers for medicare and medicaid services (CMS) in the end-stage renal disease (ESRD) section of its website, http://www.cms.gov.

(2) PVPAs for covered dialysis services are listed in the appendix to this rule.

(3) Payment separate from the PVPA may be made for the following items and services:

(a) Covered professional dialysis services provided by a medical practitioner, addressed in rule 5160-4-14 of the Administrative Code; and

(b) Covered laboratory services and pharmaceuticals, addressed in Chapter 5160-11 of the Administrative Code, that are not designated by medicare as "subject to consolidated billing."

(4) Nothing in this rule precludes a medicaid managed care organization (described in Chapters 5160-26 and 5160-58 of the Administrative Code) from paying amounts other than those listed in the appendix to this rule.