SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Member Provider Policy & Procedure Manual

5.8 DIALYSIS

This is a subsection of Section 5: Billing and Reimbursement Guidelines of the *Member Provider Policy & Procedure Manual*. If Blue Cross and Blue Shield of Louisiana (Louisiana Blue) makes any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this subsection and notify our network providers. For complete *Member Provider Policy & Procedure Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.lablue.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.lablue.com/providers.

This manual is provided for informational purposes only and is an extension of your Member Provider Agreement. You should always directly verify member benefits prior to performing services. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent. The Member Contract/Certificate contains information on benefits, limitations and exclusions, and managed care benefit requirements. It also may limit the number of days, visits or dollar amounts to be reimbursed.

As stated in your agreement: This manual is intended to set forth in detail our policies. Louisiana Blue retains the right to add to, delete from and otherwise modify the *Member Provider Policy & Procedure Manual* as needed. This manual and other information and materials provided are proprietary and confidential and may constitute trade secrets.

DIALYSIS

Dialysis providers should adhere to the following billing guidelines when filing claims:

- Providers must file dialysis claims under the appropriate revenue code for the type of treatment provided as a single line item.
- The service units field must be used to indicate the number of treatments provided within the dates of service that appear on the claim.
- All other billed charges for services or products rendered must be itemized and the appropriate HCPCS code should be included on the claim.
- Providers should use one of the following revenue codes for the dialysis procedure when submitting a UB-04 claim form. CPT codes are not required when billing for dialysis services.

Revenue Codes	Type of Dialysis
821	Hemodialysis
831	Intermittent Peritoneal Dialysis
841	Continuous Ambulatory Peritoneal Dialysis
851	Continuous Cycling Peritoneal Dialysis

Providers should use one of the following revenue codes, along with the appropriate HCPCS code, for Epogen when submitting a UB-04 claim form:

Codes	Type of Dialysis
634	EPO, less than 10,000 units
635	EPO, 10,000 or more units
Q4081	Injection, epoetin alfa, 100 units (for ESRD on dialysis)

For example: Epogen will be reimbursed at $1.20 per 100 units for Q4081. Providers should use revenue code 634 or 635 and HCPCS code Q4081 when billing for Epogen. The per diem will only be applicable to the day(s) that the treatment is provided. Any services related to dialysis treatments, but rendered on dates of service other than the date of service for dialysis treatment is included in the per diem and is not separately reimbursable.

The service units field (Block 46 of the UB-04 claim form) should include the appropriate units per the HCPCS code description for the total units provided. For example, if billing code Q4081 and 5,000 units are provided, enter "50" on Block 46.

- The per diem reimbursement only applies to the day(s) that the treatment is provided.
- Any services related to dialysis treatments, but rendered on dates of service other than the date of service for dialysis treatment, are included in the per diem and are not separately reimbursable.
- Only one dialysis per diem is reimbursable per day.

Note: Louisiana Blue may expand and/or modify the reimbursement schedule for new, deleted or modified codes developed subsequent to the effective date of your Allied Health Professional Agreement.