CHAPTER 1128. RENAL DIALYSIS SERVICES

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Authority

The provisions of this Chapter 1128 issued under section 443.3(1) of the Public Welfare Code (62 P. S. § 443.3(1)), unless otherwise noted.

Source

The provisions of this Chapter 1128 adopted April 21, 1989, effective April 22, 1989, 19 Pa.B. 1731, unless otherwise noted.

GENERAL PROVISIONS

§ 1128.1. Policy.

The MA Program pays for renal dialysis services provided to eligible MA recipients. Payment is made to participating, independently operated dialysis facilities and to hospital based dialysis facilities under this chapter and Chapter 1101 (relating to general provisions).

§ 1128.2. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Home dialysis—Dialysis performed by an appropriately trained patient or patient partner at home.

MA—Medical Assistance.

Outpatient dialysis—Dialysis furnished on an outpatient basis under the auspices of a renal dialysis facility.

Patient partner—An individual trained to assist a patient in performing self-dialysis or home dialysis.

Renal dialysis—A process by which dissolved substances are removed from a patient's body by diffusion from one fluid compartment to another across a semipermeable membrane.

Renal dialysis facility—A facility approved by the Department of Health to furnish dialysis services on an outpatient basis. A dialysis facility may be hospital based or may be operated independently of a hospital.

Self-renal dialysis—Dialysis performed at a facility with little or no professional assistance, by a dialysis patient or patient partner, who has completed an appropriate course of training.

Self-renal dialysis training and *home renal dialysis training*—A program that trains dialysis patients to perform self-dialysis or home dialysis with little or no professional assistance, and trains other individuals to assist patients in performing self-dialysis or home dialysis.

Staff-assisted dialysis—Dialysis performed by the staff of the center.

SCOPE OF BENEFITS

§ 1128.21. Scope of benefits for the categorically needy.

Categorically needy recipients registered with the Department of Health Chronic Renal Disease Program are eligible for renal dialysis services subject to this chapter.

§ 1128.22. Scope of benefits for the medically needy.

Medically needy recipients registered with the Department of Health Chronic Renal Disease Program are eligible for renal dialysis services subject to this chapter.

§ 1128.23. Scope of benefits for State Blind Pension recipients.

State Blind Pension recipients are not eligible for renal dialysis services under the MA Program unless the recipient is also categorically needy or medically needy.

§ 1128.24. Scope of benefits for General Assistance recipients.

General Assistance recipients, age 21 to 65, whose MA benefits are funded solely by State funds, are eligible for medically necessary basic health care benefits as defined in Chapter 1101 (relating to general provisions). See § 1101.31(e) (relating to scope).

Source

The provisions of this § 1128.24 adopted December 11, 1992, effective January 1, 1993, 22 Pa.B. 5995.

PROVIDER PARTICIPATION

§ 1128.41. Participation requirements.

(a) In addition to the participation requirements established in §§ 1101.41—1101.43 (relating to participation), a renal dialysis facility shall:

(1) Have a signed contractual agreement with the Department of Health Chronic Renal Disease Program.

(2) Be enrolled in the MA Program as a renal dialysis provider.

(3) Be Medicare certified in accordance with Medicare regulations at 42 CFR 405.2100—405.2171 (relating to conditions for coverage of suppliers of End-Stage Renal Disease (ESRD) services).

(4) Abide by applicable Federal and State statutes and regulations, including, but not limited to, Title XIX of the Social Security Act (42 U.S.C.A. §§ 1396—1396s), the Public Welfare Code (62 P. S. §§ 101—1411) and applicable licensing statutes.

(5) Have an established schedule of charges for billing third parties and private payors that is published and made available to the general public.

(6) If requested, furnish information to the Department necessary to establish rates as specified in § 1128.53 (relating to limitations on payment), in the form and manner the Department requires.

(b) It is the responsibility of the dialysis facility to determine that physicians associated with the facility meet the qualifications specified by the Department of Health.

(c) Out-of-State dialysis facilities providing services to Pennsylvania recipients shall, in addition to complying with the appropriate requirements of this section, either be Medicare certified or be approved or licensed by the appropriate agency of the state in which the facility is located as meeting standards comparable to Medicare.

(d) The Department reserves the right to refuse to enter into a provider agreement with a dialysis facility whenever it determines that it is in the best interest of the Program and its beneficiaries to do so.

§ 1128.42. Ongoing responsibilities of providers.

Ongoing responsibilities of providers are established in § 1101.51 (relating to ongoing responsibilities of providers).

PAYMENT FOR RENAL DIALYSIS SERVICES

§ 1128.51. General payment policy.

(a) Payment is made as set forth in this section, for support services and items related to procedures provided by participating dialysis facilities if full payment for the services and items is not available through Medicare, other financial resources or health insurance programs. Payment is subject to the conditions and limitations established in this chapter, Chapters 1101 and 1150 (relating to general provisions; and MA Program payment policies) and the MA Program Fee Schedule.

(b) A fee determined by the Department is paid for support services provided to an eligible recipient during the course of a dialysis procedure.

(c) The dialysis facility is considered the provider regardless of whether the facility is operated directly by the enrolled provider or through contract between the provider and other organizations or individuals. The enrolled provider is responsible for the delivery of service and for billings.

(d) The Department will pay for the unsatisfied portion of the Medicare deductible and remaining 20% coinsurance up to the amount of the MA fee, if the Medicare 80% payment and the amount billed to MA does not exceed the maximum MA fee.

(e) Payment is made for dialysis services provided at the site of a facility or in a patient's home.

(f) The fee paid to the facility includes, but is not limited to, the following:

(1) Nursing, technician and related services.

(2) Use of the facility.

(3) The maintenance of medical records as required by the Department of Health and under § 1101.51 (relating to ongoing responsibilities of providers.)

(4) Drugs, biologicals, surgical dressings, supplies, blood, intravenous fluids, diagnostic studies and equipment directly related to the provision of a dialysis procedure.

(5) Ongoing evaluation of patients receiving home dialysis services.

(6) Dietary, social services and other related services.

(7) Administrative and housekeeping items and services.

(g) The fees paid for procedures are applicable to staff-assisted dialysis, self dialysis and home dialysis.

(h) Payment is made in accordance with the MA Program Fee Schedule for installation of equipment and modification of a home to the extent necessary for home dialysis services.

(i) The dialysis facility shall submit invoices to the Department in accordance with the instructions in the Provider Handbook.

(j) The Department will pay the lesser of the dialysis facility's charge to the general public or the amount determined as the rate that the facility is eligible to bill.

(k) If the dialysis facility has a fee schedule based on the patient's ability to pay, the Department will consider the provider's usual and customary charge to the general public to be the most frequent charge to the self-paying public for the same service in the preceding calendar month.

(l) The Department's payment for dialysis services shall be considered payment in full as specified under § 1101.63 (relating to payment in full).

(m) If a dialysis facility voluntarily terminates the provider agreement, payment is made for services provided prior to the effective date of the termination of the provider agreement. Payment shall be made in accordance with § 1128.52 (relating to payment criteria).

(n) Payment is made for services provided to Commonwealth MA recipients by an out-of-State dialysis facility only if residents in a given area generally receive their care in that particular facility. This would apply when the out-of-State facility is closer to, or substantially more accessible from, the residence of the recipient than the nearest facility within this Commonwealth that is adequately equipped to deal with, and is available for the treatment of, the individual's illness.

Cross References

This section cited in 55 Pa. Code § 1128.53 (relating to limitations on payment).

§ 1128.52. Payment criteria.

(a) The Department will establish maximum reimbursement fees for dialysis facilities based on the following criteria:

(1) The level of reimbursement will be consistent with efficiency, economy and quality of care.

(2) The level of reimbursement will be sufficient to assure availability of services.

(3) Rate increases and decreases, and changes in the actual methodology used in establishing the maximum fees will be published as a notice in the *Pennsylvania Bulletin*.

(b) The fee for dialysis services may be decreased by the Department if:

(1) Medicare or the Department of Health Chronic Renal Disease Program payment rates decrease.

(2) The providers' Statewide average usual charge decreases.

(3) Other compelling circumstances occur under which, in the interest of the general public, the Department revises its decisions regarding maximum payment levels.

(c) With the exception of the fee for ongoing maintenance dialysis, payment is made to participating dialysis facilities at the Department of Health, Chronic Renal Disease Program rates in effect as of July 1, 1986. Changes in payment rates will be published in the *Pennsylvania Bulletin* in the form of a notice.

Cross References

This section cited in 55 Pa. Code § 1128.51 (relating to general payment policy).

§ 1128.53. Limitations on payment.

(a) The Department does not pay for services provided by a dialysis facility except as specified under § 1128.51 (relating to general payment policy).

(b) Payment will not be made for services provided by facility based or contract employes if the services are those specified under § 1128.51.

(c) Payment is limited to services provided to recipients who meet Federal Medicaid eligibility requirements and who are enrolled in the Department of Health Chronic Renal Disease Program.

(d) Payment is limited to one procedure including related services, per day.

(e) Initial training for home dialysis is limited to 24 sessions per patient or partner.

(f) Payment for backup visits to the facility is limited to no more than 15 in one calendar year. For the purposes of this chapter, backup procedures are dialysis procedures provided at a facility when a patient is required to resume treatment at the facility following home dialysis treatment. Backup services may be necessitated by worsening of the patient's condition, absence of the dialysis treatment partner, or for the purpose of training a new partner or retraining for a new procedure to be managed in the home.

(g) Payment for nonexpendable equipment or installation of equipment necessary for home dialysis procedures is limited to one time per patient per item.

Cross References

This section cited in 55 Pa. Code § 1128.41 (relating to participation requirements).

§ 1128.54. Noncompensable services and items.

The Department does not pay dialysis facilities for:

(1) Services that do not conform to this chapter.

(2) Services provided by a dialysis facility that does not meet the Federal Medicare requirements at 42 CFR 405.2100 (relating to scope of subpart).

(3) Services and items to the extent that payment is available through Medicare, other health insurance programs or financial resources.

(4) Diagnostic or therapeutic procedures solely for experimental, research or educational purposes.

(5) Procedures that are not listed in the MA Program fee schedule.

(6) Services that are not medically necessary.

(7) Services provided to recipients who are hospital inpatients.

UTILIZATION CONTROL

§ 1128.71. Scope of claims review procedures.

Claims submitted for payment under the MA Program are subject to the utilization review procedures established in § 1101.71 (relating to utilization control).

ADMINISTRATIVE SANCTIONS

§ 1128.81. Provider misutilization.

A provider determined to have billed for services inconsistent with MA Program regulations, to have provided services outside the scope of customary standards of medical practice or to have otherwise violated the standards in the provider agreement, is subject to the sanctions described in Chapter 1101 (relating to general provisions).

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