Washington State Health Care Authority

Washington Apple Health (Medicaid)

Kidney Center Services Billing Guide

October 1, 2018

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and an agency rule arises, the agency rules apply.

About this guide*

This publication takes effect October 1, 2018, and supersedes earlier guides to this program.

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> Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

What has changed?

Subject	Change	Reason for Change
Revenue codes	Added coverage for HCPCS codes J7503 and J7510	Fee schedule update, effective 10/1/2018
How do I request prior authorization for a limitation extension (LE)?	Providers may now submit prior authorization (PA) requests online through direct data entry into ProviderOne	New online option available for requesting PA

* This publication is a billing instruction.

How can I get agency provider documents?

To download and print agency provider notices and billing guides, go to the agency's Provider Publications website.

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Definitions

This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to Chapter 182-500 WAC for a complete list of definitions for Washington Apple Health.

Affiliate - A facility, hospital, unit, business, or person having an agreement with a kidney center to provide specified services to ESRD patients.

Agreement - A written document executed between an ESRD facility and another facility in which the other facility agrees to assume responsibility for furnishing specified services to patients and for obtaining payment for those services.

Back-Up Dialysis - Dialysis given to patients under special circumstances in a situation other than the patients' usual dialysis environment. Examples are:

- Dialysis of a home dialysis patient in a dialysis facility when patient's equipment fails.
- In-hospital dialysis when the patient's illness requires more comprehensive care on an inpatient basis.
- Pre- and post-operative dialysis provided to transplant patients.

Composite Rate - This refers to a payment method in which all standard equipment, supplies, and services are calculated into a blended rate. All in-facility dialysis treatments and all home dialysis treatments are billed under the composite rate system.

Continuous Ambulatory Peritoneal Dialysis (CAPD) - A type of dialysis where the patient's peritoneal membrane is used as the dialyzer. The patient dialyzes at home, using special supplies, but without the need for a machine (see Peritoneal Dialysis).

Continuous Cycling Peritoneal Dialysis (CCPD) - A type of peritoneal dialysis where the patient dialyzes at home and utilizes an automated peritoneal cycler for delivering dialysis.

Dialysate - An electrolyte solution, containing elements such as potassium, sodium-chloride, etc., surrounding the membrane or fibers and allowing exchange of substances with the patient's blood in the dialyzer.

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.

Dialysis Session - The period of time beginning when the patient arrives at the facility and ending when the patient departs from the facility. In the case of home dialysis, the time period beginning when the patient prepares for dialysis and ending when the patient is disconnected from the machine.

Dialyzer - Synthetic porous membrane or fibers, contained in a supporting structure, through which blood flows for the purpose of eliminating harmful substances and replacing with useful ones.

End-Stage Renal Disease (ESRD) - The stage of renal impairment that is irreversible and permanent, and requires dialysis or kidney transplantation to ameliorate uremic symptoms and maintain life.

Epoetin Alpha (EPO) - An injectable drug that is a biologically engineered protein that stimulates the bone marrow to make new red blood cells.

Free-Standing Kidney Center - A limited care facility, not operated by a hospital, certified by the federal government to provide ESRD services.

Hemodialysis - A method of dialysis in which blood from a patient's body is circulated through an external device or machine and then returned to the patient's bloodstream. Hemodialysis is usually done in a kidney center or facility. It can be done at home with a trained helper.

Home Dialysis - Refers to any dialysis performed at home.

Home Dialysis Helper - A person trained to assist the client in home dialysis.

In-Facility Dialysis - For the purpose of this guide only, in-facility dialysis is dialysis of any type performed on the premises of the kidney center or other free-standing ESRD facility.

Intermittent Peritoneal Dialysis (IPD) - A type of peritoneal dialysis in which dialysis solution is infused into the peritoneal cavity, allowed to remain there for a period of time, and then drained out. IPD is usually done in a kidney center or facility. It can be done at home with a trained home dialysis helper.

Kidney Center - A facility as defined and certified by the federal government to:

- Provide ESRD services.
- Provide the services specified in this chapter.
- Promote and encourage home dialysis for a client when medically indicated.

Maintenance Dialysis - The usual periodic dialysis treatments given to a patient who has ESRD.

Peritoneal Dialysis - A procedure that introduces dialysate into the abdominal cavity to remove waste products through the peritoneum. Three forms of peritoneal dialysis are: Continuous Ambulatory Peritoneal Dialysis, Continuous Cycling Peritoneal Dialysis, and Intermittent Peritoneal Dialysis.

Self-Dialysis Unit - A unit in a free-standing kidney center where dialysis is performed by an ESRD client who has completed training in self-dialysis.

About the Program

(WAC 182-540-101)

What is the purpose of the Kidney Center Services program?

The purpose of the Kidney Center Services program is to assist low-income residents with the cost of treatment for end-stage renal disease (ESRD).

What are the provider requirements?

(WAC 182-540-120)

To receive payment from the agency for providing care to eligible clients, a kidney center must:

- Be a Medicare-certified ESRD facility
- Have a signed Core Provider Agreement (CPA) with the agency and meet the requirements in WAC 182-502 Administration of Medical Programs-Providers. Visit the Provider Enrollment website for further information on the CPA.
- Provide only those services that are within the scope of their provider's license
- Provide services, either directly or through an affiliate, all physical facilities, professional consultation, personal instructions, medical treatment, care, and all supplies necessary for carrying out a medically-sound ESRD treatment program. Services include:
  - ✓ Dialysis for clients with ESRD
  - ✓ Kidney transplant treatment for ESRD clients when medically indicated
  - ✓ Treatment for conditions directly related to ESRD
  - ✓ Training and supervision of supporting personnel and clients for home dialysis, medical care, and treatment
  - ✓ Supplies and equipment for home dialysis

Is it required that clients be notified of their rights (Advance Directives)?

Yes. All Medicare/Medicaid-certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment
- Make decisions concerning their own medical care
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care

Client Eligibility

(WAC 182-540-110(1))

Most Apple Health clients are enrolled in an agency-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCO's provider network, unless prior authorized or to treat urgent or emergent care. See the agency's Apple Health managed care page for further details.

It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.

How do I verify a client's eligibility?

Check the client's Services Card or follow the two-step process below to verify that a client has Apple Health coverage for the date of service and that the client's benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

Is the client enrolled in an agency-contracted managed care organization (MCO), in a behavioral health organization (BHO), or is the client receiving services through fee-for-service (FFS) Apple Health?

Verifying eligibility is a two-step process:

Step 1. **Verify the patient's eligibility for Apple Health.** For detailed instructions on verifying a patient's eligibility for Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in the agency's ProviderOne Billing and Resource Guide.

If the patient is eligible for Apple Health, proceed to **Step 2**. If the patient is **not** eligible, see the note box below.

Step 2. **Verify service coverage under the Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see the agency's Program Benefit Packages and Scope of Services webpage.

Note: Patients who are not Apple Health clients may submit an application for health care coverage in one of the following ways:

1. By visiting the Washington Healthplanfinder's website at: www.wahealthplanfinder.org

2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)

3. By mailing the application to:
   Washington Healthplanfinder
   PO Box 946
   Olympia, WA 98507

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit www.wahealthplanfinder.org or call the Customer Support Center.

Are clients enrolled in an agency-contracted managed care organization (MCO) eligible?

(WAC 182-540-110(2))

Yes. Most Medicaid-eligible clients are enrolled in one of the agency's contracted managed care organizations (MCOs). For these clients, managed care enrollment will be displayed on the client benefit inquiry screen in ProviderOne.

All medical services covered under an agency-contracted MCO must be obtained by the client through designated facilities or providers. The MCO is responsible for:

- Payment of covered services
- Payment of services referred by a provider participating with the plan to an outside provider

The client's plan covers hemodialysis or other appropriate procedures to treat renal failure, including equipment needed in the course of treatment.

Note: A client's enrollment can change monthly. Providers who are not contracted with the MCO must receive approval from **both** the MCO and the client's primary care provider (PCP) prior to serving a managed care client.

Send claims to the client's MCO for payment. Call the client's MCO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in WAC 182-502-0160

Note: To prevent billing denials, check the client's eligibility **prior** to scheduling services and at the **time of the service**, and make sure proper authorization or referral is obtained from the agency-contracted MCO, if appropriate. See the agency's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

Managed care enrollment

Apple Health (Medicaid) places clients into an agency-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. This eliminates a person being placed temporarily in FFS while they are waiting to be enrolled in an MCO or reconnected with a prior MCO. This enrollment policy also applies to clients in FFS who have a change in the program they are eligible for.

New clients are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health managed care. Renewing clients are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

Checking eligibility

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to the Washington Healthplanfinder's Get Help Enrolling page.

- MCOs have retroactive authorization and notification policies in place. The provider must know the MCO's requirements and be compliant with the MCO's policies.

Behavioral Health Organization (BHO)

Effective July 1, 2018, the Health Care Authority manages the contracts for behavioral health services (mental health and substance use disorder) for eight of the Regional Service Areas (RSAs) in the state. The remaining regions have fully integrated managed care (FIMC).

See the agency's Mental Health Services Billing Guide for details.

Fully Integrated Managed Care (FIMC)

For clients who live in an FIMC region, all physical health services, mental health services, and drug and alcohol treatment are covered and coordinated by the client's agency-contracted MCO. The BHO will not provide behavioral health services in these counties.

Clients living in an FIMC region will enroll with an MCO of their choice that is available in that region. If the client does not choose an MCO, the client will be automatically enrolled into one of the available MCOs, unless the client is American Indian/Alaska Native (AI/AN). Clients currently enrolled in one of the available MCOs in their region may keep their enrollment when the behavioral health services are added.

Effective July 1, 2017, American Indian/Alaska Native (AI/AN) clients living in an FIMC region of Washington may choose to enroll in one of the agency-contracted MCOs available in that region or they may choose to receive all these services through Apple Health FFS. If they do not choose an MCO, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the agency's American Indian/Alaska Native webpage.

For more information about the services available under the FFS program, see the agency's Mental Health Services Billing Guide and the Substance Use Disorder Billing Guide.

For full details on FIMC, see the agency's Changes to Apple Health managed care webpage.

FIMC Regions

Clients who reside in either of the following two FIMC regions and who are eligible for managed care enrollment must choose an available MCO in their region. Specific details, including information about mental health crisis services, can be found on the agency's Apple Health managed care webpage.

North Central Region – Douglas, Chelan and Grant Counties
Effective January 1, 2018, the agency implemented the second FIMC region known as the North Central Region, which includes Douglas, Chelan, and Grant Counties.

Southwest Washington Region – Clark and Skamania Counties
Effective April 1, 2016, the agency implemented the first FIMC region known as the Southwest Washington Region, which includes Clark and Skamania Counties. Clients eligible for managed care enrollment choose to enroll in one of two available MCOs in this region.

Apple Health Foster Care (AHFC)

Coordinated Care of Washington (CCW) provides all physical health care (medical) benefits, lower-intensity outpatient mental health benefits and care coordination for all Washington State foster care enrollees through a single, statewide managed care plan known as Apple Health Core Connections (AHCC).

Clients under this program are:

- Under the age of 21 who are in foster care (out of home placement)
- Under the age of 21 who are receiving adoption support
- Age 18-21 years old in extended foster care
- Age 18 to 26 years old who aged out of foster care on or after their 18th birthday (alumni)

These clients are identified in ProviderOne as
"**Coordinated Care Healthy Options Foster Care.**"

See the agency's Apple Health managed care page, Apple Health Foster Care for further details.

Coverage

What is not covered?

(WAC 182-540-140)

The agency does not cover services provided in a kidney center such as:

- Blood and blood products (see WAC 182-540-190)
- Personal care items such as slippers, toothbrushes, etc.
- Additional staff time or personnel costs. Staff time is paid through the composite rate. **Exception:** Staff time for home dialysis helpers is the only personnel cost paid outside the composite rate (see WAC 182-540-160).

The agency or its designee reviews all initial requests for noncovered services based on WAC 182-501-0160.

What is covered?

(WAC 182-540-130)

- The agency covers and pays for only the blood bank service charge for processing blood and blood products (see WAC 182-550-6500).
- The agency covers services including all of the following:

  ✓ In-facility dialysis
  ✓ Home dialysis
  ✓ Self-dialysis training
  ✓ Home dialysis helpers
  ✓ Dialysis supplies
  ✓ Diagnostic lab work
  ✓ Treatment for anemia
  ✓ Intravenous drugs

Note: Home dialysis helpers may assist a client living in the client's home or in a skilled nursing facility (when the skilled nursing facility is their home) with home dialysis.

- Covered services are subject to the restrictions and limitations in this guide and applicable WAC as specified by the agency. Providers must obtain a limitation extension (LE) before providing services that exceed specified limits in quantity, frequency, or duration. See Authorization for specifics on the LE process.

What types of service are covered by other agency programs?

(WAC 182-540-150(3-4))

Other agency programs cover the following services:

- **Take Home Drugs** – Take home drugs (outpatient prescription drugs not being administered in the provider's office) must be supplied and billed by a pharmacy, subject to pharmacy pricing methodology outlined in the agency's current Prescription Drug Program Billing guide.

- **Medical Nutrition** – Only pharmacies or other medical nutrition providers may supply supplemental food products. Bill for medical nutrition services using the agency's current Enteral Nutrition Billing guide.

What HCPCS codes for blood processing are used in outpatient blood transfusions?

The codes listed below must be used to represent costs for:

- ✓ Blood processing and other fees assessed by nonprofit blood centers that do not charge for the blood and blood products themselves.

- ✓ Costs incurred by a center to administer its in-house blood procurement program. However, these costs must not include any staff time used to administer blood.

HCPCS Code	Short Descriptions	Policy/ Comments
P9010	Whole blood for transfusion	
P9011	Blood split unit	
P9012	Cryoprecipitate each unit	
P9016	Rbc leukocytes reduced	
P9017	Fresh frozen plasma (single donor), each unit	
P9019	Platelets, each unit	
P9020	Platelet rich plasma unit	
P9021	Red blood cells unit	
P9022	Washed red blood cells unit	
P9023	Frozen plasma, pooled, sd	
P9031	Platelets leukocytes reduced	
P9032	Platelets, irradiated	
P9033	Platelets leukoreduced irrad	
P9034	Platelets, pheresis	
P9035	Platelet pheres leukoreduced	
P9036	Platelet pheresis irradiated	
P9037	Plate pheres leukoredu irrad	
P9038	Rbc irradiated	
P9039	Rbc deglycerolized	
P9040	Rbc leukoreduced irradiated	
P9041	Albumin (human), 5%, 50 ml	
P9043	Plasma protein fract, 5%, 50 ml	
P9044	Cryoprecipitatereducedplasma	
P9045	Albumin (human), 5%, 250 ml	
P9046	Albumin (human), 25%, 20 ml	
P9047	Albumin (human), 25%, 50 ml	
P9048	Plasmaprotein fract, 5%, 250 ml	
P9050	Granulocytes, pheresis unit	
P9054	Blood, l/r, froz/degly/wash	
P9055	Plt, aph/pher, l/r, cmv-neg	
P9056	Blood, l/r, irradiated	
P9057	Rbc, frz/deg/wsh, l/r, irrad	
P9058	Rbc, l/r, cmv-neg, irrad	
P9059	Plasma, frz between 8-24 hour	
P9060	Fr frz plasma donor retested	

Revenue codes

Revenue Code	HCPCS Code	Short Description	Policy/ Comments
Medical/Surgical Supplies and Devices (Requires specific identification using a HCPCS code)			
Note: In order to receive payment for **revenue code 0270**, the HCPCS code of the specific supply given must be indicated in the *Procedure Code* field of the institutional claim. Payment is limited to **those supplies listed below**.			
0270		Medical/surgical supplies and devices	
0270	A4657	Syringe w/wo needle	
0270	A4750	Art or venous blood tubing	
0270	A4913	Misc dialysis supplies noc	
Laboratory			
Note: In order to receive payment for **revenue code 0300,** the following modifiers must be used: • *CB - Service ordered by a renal dialysis facility (RDF) physician as part of the ESRD beneficiary's dialysis benefit, is not part of the composite rate, and is separately reimbursable. • **CE - AMCC test has been ordered by an ESRD facility or MCP physician that is a composite rate test, but is beyond the normal frequency covered under the rate and is separately reimbursable based on medical necessity.			
0300		Laboratory, General Classification	*Not part of the composite rate **or** **Beyond normal frequency covered
0303		Laboratory, renal patient (home)	
0304		Laboratory, non-routine dialysis	
Drugs			
Note: Providers must use the correct 11-digit National Drug Code (NDC) when billing the agency for drugs administered to eligible clients in kidney centers.			
Epoetin Alpha (EPO)			
Note: When billing with **revenue codes 0634 and 0635**, each billing unit reported on the claim form represents **100 units** of EPO given.			
0634		Erythropoietin (EPO) less than 10,000 units	
0634	Q4081	Epoetin alfa, 100 units ESRD	100 units
0635		Erythropoietin (EPO) 10,000 or more units	

Revenue Code	Procedure Code	Short Description		Policy/ Comments
Other Drugs Requiring Specific Identification				
Note: In order to receive payment for **revenue code 0636**, the HCPCS code of the specific drug given must be indicated in the *Procedure Code* field of the institutional claim. Payment is limited to **the drugs listed below.**				
0636		Administration of drugs		Bill number of units based on the description of the drug code)
0636	90656	Flu vaccine no preserv 3 & >		
0636	90657	Flu vaccine 3 yrs im		
0636	90658	Flu vaccine 3 yrs & > im		
0636	90670	Pneumococcal conjugate vaccine, 13 valent, for intramuscular use		
0636	90673	Flu vaccine no preserv im		
0636	90674	Flu vaccine 4yo & > im	0.5 ml	
0636	90686	Flu vaccine 3 yrs & > im		
0636	90732	Pneumococcal vaccine		
0636	90747	Hepb vacc ill pat 4 dose im	40 mcg	
0636	J0280	Aminophyllin 250 mg inj	250 mg	
0636	J0285	Amphotericin B	50 mg	
0636	J0290	Ampicillin 500 mg inj	500 mg	
0636	J0295	Ampicillin sodium per 1.5 gm	1.5 g	
0636	J0360	Hydralazine hcl injection	20 mg	
0636	J0604	Cinacalcet	1 mg	PA required
0636	J0606	Etelcalcetide, injection	0.1 mg	PA required
0636	J0610	Calcium gluconate injection	10 ml	
0636	J0630	Calcitonin salmon injection	400 u	
0636	J0636	Inj calcitriol per 0.1 mcg	0.1 mcg	
0636	J0640	Leucovorin calcium injection	50 mg	
0636	J0690	Cefazolin sodium injection	500 mg	
0636	J0692	Cefepime HCl for injection	500 mg	
0636	J0694	Cefoxitin sodium injection	1 gm	
0636	J0696	Ceftriaxone sodium injection	250 mg	
0636	J0697	Sterile cefuroxime injection	750 mg	
0636	J0698	Cefotaxime sodium injection	per g	
0636	J0702	Betamethasone acet&sod phosp	3 mg	
0636	J0710	Cephapirin sodium injection	1gm	
0636	J0713	Inj ceftazidime per 500 mg	500 mg	
0636	J0743	Cilastatin sodium injection	per 250 mg	
0636	J0780	Prochlorperazine injection	10 mg	

Revenue Code	Procedure Code	Short Description		Policy/ Comments
0636	J0878	Daptomycin injection	1 mg	
0636	J0882	Darbepoetin alfa, esrd use	1 mcg	
0636	J0887	Epoetin beta injection	1 mcg	
0636	J0895	Deferoxamine mesylate inj	500 mg	
0636	J0970	Estradiol valerate injection	40 mg	
0636	J1094	Inj dexamethasone acetate	1 mg	
0636	J1160	Digoxin injection	0.5 mg	
0636	J1165	Phenytoin sodium injection	50 mg	
0636	J1170	Hydromorphone injection	4 mg	
0636	J1200	Diphenhydramine hcl injection	50 mg	
0636	J1240	Dimenhydrinate injection	50 mg	
0636	J1270	Injection, doxercalciferol	1 mcg	
0636	J1335	Ertapenem injection	500 mg	
0636	J1580	Garamycin gentamicin inj	80 mg	
0636	J1630	Haloperidol injection	5 mg	
0636	J1631	Haloperidol decanoate inj	50 mg	
0636	J1645	Dalteparin sodium	2500 IU	
0636	J1720	Hydrocortisone sodium succ i	100 mg	
0636	J1750	Inj iron dextran	50 mg	
0636	J1756	Iron sucrose injection	1 mg	
0636	J1790	Droperidol injection	5 mg	
0636	J1800	Propranolol injection	1 mg	
0636	J1840	Kanamycin sulfate 500 mg inj	500 mg	
0636	J1885	Ketorolac tromethamine inj	15 mg	
0636	J1890	Cephalothin sodium injection	1 gm	
0636	J1940	Furosemide injection	20 mg	
0636	J1955	Inj levocarnitine per 1 gm	1 gm	
0636	J1956	Levofloxacin injection	250 mg	
0636	J1990	Chlordiazepoxide injection	100 mg	
0636	J2001	Lidocaine injection	10 mg	
0636	J2060	Lorazepam injection	2 mg	
0636	J2150	Mannitol injection	50 ml	
0636	J2175	Meperidine hydrochl /100 mg	100 mg	
0636	J2185	Meropenem	100 mg	
0636	J2270	Morphine sulfate injection	10 mg	
0636	J2320	Nandrolone decanoate 50 mg	50 mg	
0636	J2501	Paricalcitol	1 mcg	
0636	J2510	Penicillin g procaine inj	600,000u	
0636	J2540	Penicillin g potassium inj	600,000u	
0636	J2550	Promethazine hcl injection	50 mg	

Revenue Code	Procedure Code	Short Description		Policy/ Comments
0636	J2560	Phenobarbital sodium inj	120 mg	
0636	J2690	Procainamide hcl injection	1 gm	
0636	J2700	Oxacillin sodium injection	250 mg	
0636	J2720	Inj protamine sulfate/10 mg	10 mg	
0636	J2765	Metoclopramide hcl injection	10 mg	
0636	J2800	Methocarbamol injection	10 ml	
0636	J2916	Na ferric gluconate complex	12.5 mg	
0636	J2920	Methylprednisolone injection	40 mg	
0636	J2930	Methylprednisolone injection	125 mg	
0636	J2995	Inj streptokinase /250000 IU	250,000 IU	
0636	J2997	Alteplase recombinant	1 mg	
0636	J3000	Streptomycin injection	1 gm	
0636	J3010	Fentanyl citrate injection	0.1 mg	
0636	J3070	Pentazocine injection	30 mg	
0636	J3230	Chlorpromazine hcl injection	50 mg	
0636	J3250	Trimethobenzamide hcl inj	200 mg	
0636	J3260	Tobramycin sulfate injection	80 mg	
0636	J3280	Thiethylperazine maleate inj	10 mg	
0636	J3301	Triamcinolone acet inj NOS	10 mg	
0636	J3360	Diazepam injection	5 mg	
0636	J3364	Urokinase 5000 IU injection	5,000 IU vial	
0636	J3365	Urokinase 250,000 IU inj	250,000 IU vial	
0636	J3370	Vancomycin hcl injection	500 mg	
0636	J3410	Hydroxyzine hcl injection	25 mg	
0636	J3420	Vitamin b12 injection	1,000 mcg	
0636	J3430	Vitamin k phytonadione inj	1mg	
0636	J7500	Azathioprine oral 50 mg	50 mg	
0636	J7502	Cyclosporine oral 100 mg	100 mg	
0636	J7503	Tacrol envarsus ex rel oral	0.25 mg	PA required when Medicaid primary
0636	J7504	Lymphocyte immune globulin	250 mg	PA required
0636	J7507	Tacrolimus imme rel oral 1mg	per 1 mg	
0636	J7508	Tacrol astagraf ex rel oral	0.1 mg	
0636	J7510	Prednisolone oral per 5 mg	5 mg	PA required when Medicaid primary
0636	J7512	Prednisone ir or dr oral 1mg	1 mg	
0636	J7515	Cyclosporine oral 25 mg	25 mg	

Revenue Code	Procedure Code	Short Description		Policy/ Comments
0636	J7517	Mycophenolate mofetil oral	250 mg	
0636	J7518	Mycophenolic acid	180 mg	
0636	J7520	Sirolimus, oral	1 mg	
0636	J7527	Oral everolimus	0.25 mg	
0636	J3490	Drugs unclassified injection		PA required
Note: The National Drug Code (NDC) number and dosage given to the client must be included in the *Claim Note* section of the claim when billing unlisted drug HCPCS code J3490.				
	Q2037	Fluvirin vacc, 3 yrs & >, im		
	Q2038	Fluzone vacc, 3 yrs & >, im		
EKG/ECG (Electrocardiogram) – Technical Portion Only				
0730		General classification		
	93005	Electrocardiogram tracing		
Hemodialysis – Outpatient or Home				
0821	90999	Hemodialysis/composite rate.		Limited to 14 per client, per month. **(Do not bill in combination with 831, 841, or 851.)** See EPA criteria for greater than 14 in-center hemodialysis treatments per month
0825		Support Services		(Home Helper)
Intermittent Peritoneal Dialysis – Outpatient or Home				
0831		Peritoneal dialysis/Composite Rate.		Limited to 14 per client, per month. **(Do not bill in combination with 821, 841, or 851.)**
0835		Support Services		(Home Helper)
Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient or Home				
0841		CAPD/Composite Rate.		Limited to 31 per client, per month. **(Do not bill in combination with 821, 831, or 851.)**
0845		Support Services		(Home Helper)
0851		Continuous cycling peritoneal dialysis/Composite Rate.		Limited to 31 per client, per month. **(Do not bill in combination with 821, 831, or 841.)**

Revenue Code	Procedure Code	Short Description		Policy/ Comments
0855		Support Services		(Home Helper)

Authorization

(WAC 182-531-0200)

What is expedited prior authorization (EPA)?

EPA is designed to eliminate the need for written authorization. The agency establishes authorization criteria and identifies the criteria with specific codes, enabling providers to create an EPA number using those codes.

To bill the agency for diagnostic conditions, procedures, and services that meet the EPA criteria, the provider must **create a 9-digit EPA number.** The first five or six digits of the EPA number must be **87000 or 870000**. The last three or four digits must be the code assigned to the diagnostic condition, procedure, or service that meets the EPA criteria. Enter the EPA number on the billing form in the authorization number field, or in the **Authorization** or **Comments** section when billing electronically.

The agency denies claims submitted without a required EPA number.

The agency denies claims submitted without the appropriate diagnosis, procedure code, or service as indicated by the last three digits of the EPA number.

The billing provider must document in the client's file how the EPA criteria were met and make this information available to the agency on request. If the agency determines the documentation does not support the criteria being met, the claim will be denied.

> **Note:** The agency requires prior authorization either by online submission or written/fax prior authorization when there is no option to create an EPA number.

EPA guidelines

Documentation

The provider must verify medical necessity for the EPA number submitted. The client's medical record documentation must support the medical necessity and be available upon the agency's request. If the agency determines the documentation does not support the EPA criteria requirements, the claim will be denied**.**

EPA Criteria Coding List

A complete EPA number is nine digits. The first five or six digits of the EPA number must be **87000 or 870000**. The last three or four digits must be the code assigned to the diagnostic condition, procedure, or service that meets the EPA criteria.

If the client does not meet the EPA criteria, prior authorization (PA) is required (see Prior Authorization).

EPA Code	Service Name	Criteria
870001376	Hemodialysis treatments, more than 14 per month	To be paid for more than 14 in-center hemodialysis treatments per month, the client's medical records must support the need for additional dialysis treatments as defined by one of the following: • Unable to obtain adequate dialysis as defined by Kt/V > 1.4 with 5 hours three times per week • Refractory Fluid Overload – successive post dialysis weight increases over three runs or more (minimum 4 hour treatment) • Uncontrolled Hypertension as defined by needing 3 blood pressure medications or more and still having a pre-dialysis BP > 140/90 • Heart failure: class III C or worse (defined by New York Heart Association (NYHA) Functional Classification) or history of decompensation with HD < 4x per week (decompensation may include increase in edema, dyspnea, increased diuretic therapy, hospitalizations from heart failure) • Unable to complete run - compromised access – termed treatment early (i.e., clotted line), must meet medical necessity. • Pregnancy • Established on >14 runs per month due to one of the above noted reasons (supportive documentation required) In addition, a signed prescription for additional dialysis by a nephrologist must be in the medical record. The agency requires prior authorization (PA) if the EPA criteria above is not met. The agency may approve more than 14 in-center hemodialysis treatments for up to a 6-month period.

What is a limitation extension (LE)?

A limitation extension (LE) is the agency's authorization for the provider to furnish more units of service than are allowed in WAC and agency billing guides. The provider must provide justification that the additional units of service are medically necessary.

LEs do not override the client's eligibility or program limitations. Not all categories of eligibility can receive all services. **For example:** Kidney dialysis is not covered under the Family Planning Only Program.

Is prior authorization required for an LE?

Yes. Prior authorization is required for an LE.

Note: See the agency's ProviderOne Billing and Resource Guide for more information on requesting authorization.

How do I request prior authorization for an LE?

To request a limitation extension (LE), providers may submit a request online through direct data entry into ProviderOne (see the agency's Prior authorization web page for details) or providers may use the written or fax authorization process.

Written or fax authorization is the paper authorization process providers may also use when submitting a request for an LE. Providers must complete:

- A General Information for Authorization form, 13-835. This request form MUST be the initial page when you submit your request.
- A Fax/Written Request Basic Information form, 13-756, all the documentation listed on this form, and any other medical justification.

Fax the forms and all documentation to **866-668-1214**.

Payment

How does the agency pay for kidney center services?

(WAC 182-540-150)

The agency pays free-standing kidney centers for providing kidney center services to eligible clients using either the:

- **Composite rate payment method** – A payment method in which all standard equipment, supplies, and services are calculated into a blended rate. All in-facility dialysis and all home dialysis treatments are billed under the composite rate method.

  - ✓ A single dialysis session and related services are paid through a single composite rate payment (see What is included in the composite rate? for a detailed description on what is required and paid for in a composite rate payment).

  - ✓ The composite rate is listed in the Kidney Center Services Fee Schedule.

-OR-

- **Noncomposite rate payment method** – End-Stage Renal Disease (ESRD) services and items covered by the agency, but not included in the composite rate, are billed and paid separately. This methodology uses a maximum allowable fee schedule to pay providers (see Can services and supplies that are not included in the composite rate be billed separately? for more detail on noncomposite rate payments).

> **Note:** The agency recognizes a free-standing kidney center as an outpatient facility. All services for the same episode of care or visit must be billed on the same claim form.

What is included in the composite rate?

(WAC 182-540-160)

The composite rate for equipment, supplies, and services for in-facility and home dialysis includes:

- Medically necessary dialysis equipment
- Dialysis services furnished by the facility's staff
- Standard ESRD-related laboratory tests (see Laboratory Services)

- Home dialysis support services including the delivery, installation, and maintenance of equipment
- Purchase and delivery of all necessary dialysis supplies
- Declotting of shunts and any supplies used to declot shunts
- Oxygen used by the client and the administration of oxygen
- Staff time used to administer blood and nonroutine parenteral items
- Non-invasive vascular studies
- Training for self-dialysis and home dialysis helpers

The agency issues a composite rate payment only when all of the above items and services are furnished or available at each dialysis session. If the facility fails to furnish or have available **any** of the above items, the agency does not pay for any part of the items and services that were furnished.

How many dialysis sessions are included in the composite rate payment?

(WAC 182-540-150(a)(2) and (3))

The composite rate payment includes the following number of sessions:

Limit per session	Revenue code
14 per client, per month	821 and 831
31 per client, per month	841 and 851

Note: Providers may request a limitation extension (LE) if more sessions than indicated above are medically necessary (see Prior Authorization).

Can services and supplies that are not included in the composite rate be billed separately?

(WAC 182-540-170)

Supplies and services that are **not** included in the composite rate may be billed separately when they are:

- Drugs related to treatment, including but not limited to Epoetin Alpha (EPO) and diazepam. The drug must:

  - ✓ Be prescribed by a physician
  - ✓ Meet the rebate requirements described in WAC 182-530-7500
  - ✓ Meet the requirements of WAC 246-905-020 when provided for home use

- Supplies used to administer drugs and blood
- Blood processing fees charged by the blood bank (see What does the agency pay free-standing kidney centers for?
- Home dialysis helpers

The above items are subject to the restrictions or limitations in this billing guide and applicable WAC.

Note: Staff time for the administration of blood is included in the composite rate.

What laboratory services are included in the composite rate?

(WAC 182-540-180)

- Standard ESRD lab tests are included in the composite rate when performed at recommended intervals.

- The following standard ESRD lab tests, performed by either the facility or an independent laboratory, may be paid outside the composite rate when it is medically necessary to test more frequently. When submitting a claim for tests performed over and above recommended intervals:

  ✓ Proof of medical necessity must be documented in the client's medical record when billing for more frequent testing. A diagnosis of ESRD is not sufficient.

  ✓ The claim must include information on the nature of the illness or injury (diagnosis, complaint, or symptom) requiring the performance of the test(s).

  ✓ (An ICD diagnosis code may be shown in lieu of a narrative description.)

Frequency of Testing Under ESRD Composite Rate	Standard ESRD Test			
1. Per Treatment	All hematocrit, hemoglobin, and clotting tests			
2. Weekly	Prothrombin time for patients on anti- coagulant therapy Serum Creatinine BUN			
3. Monthly	Alkaline Phosphatase CBC LDH Serum Albumin Serum Bicarbonate Serum Calcium		Serum Chloride Serum Phosphorous Serum Potassium SGOT Total Protein	
	<u>CAPD Tests:</u>			
	Albumin Alkaline BUN Calcium CO2	Creatinine Dialysate Protein HCT HGB LDH	Magnesium Phosphatase Phosphate Potassium SGOT	Sodium Total Protein

The following tests are **not** included in the composite rate and may be billed at the frequency shown without medical documentation. Tests performed more frequently require the appropriate medical diagnosis and medical documentation in the client's medical record. (A diagnosis of ESRD alone is not sufficient.)

Frequency of Testing for Separately Billable Tests	Test
Hemodialysis & CCPD Patients	
Once every three months	Serum Aluminum Serum Ferritin
Once every twelve months	Bone Survey (Either the roetgenographic method or the photon absorptiometric procedure for bone mineral analysis.)
	Assay of parathormone (83970)
CAPD Patients	
Once every three months:	Platelet count RBC WBC
Once every six months:	Residual renal function 24-hour urine volume

- All separately billable ESRD laboratory services must be billed by, and paid to, the laboratory that performs the test.

What does the agency pay free-standing kidney centers for?

(WAC 182-540-190)

The agency pays free-standing kidney centers for:

- Blood processing and other fees assessed by non-profit blood centers that do not charge for the blood or blood products themselves
- Costs, up to the agency maximum allowable fee, incurred by the center to administer its in-house blood procurement program

The agency does not pay free-standing kidney centers for blood or blood products (see **WAC** 182-550-6500).

Staff time used to administer blood or blood products is included in the payment for the composite rate (see **WAC** 182-540-150 and 182-540-160).

When does the agency pay for Epoetin Alpha (EPO) therapy?

(WAC 182-540-200(2)(a) and (b))

The agency pays the kidney center for EPO therapy when:

- Administered in the kidney center to a client who meets one of the following:
  - ✓ Has a hematocrit less than 33 percent or a hemoglobin less than 11 when therapy is initiated
  - ✓ Is continuing EPO therapy with a hematocrit between 30 and 36 percent
- Provided to a home dialysis client when both of the following apply:
  - ✓ The client has a hematocrit less than 33% or a hemoglobin less than 11 when therapy is initiated.
  - ✓ EPO therapy is permitted by Washington Board of Pharmacy Rules (see **WAC** 246-905-020 Home dialysis program - legend drugs).

For billing purposes, **100 units of EPO given to the client equals one (1) billing unit**. If a fraction of 100 units of EPO is given, round the billing unit as follows:

- If 49 units or less are given, round down to the next 100 units (i.e., bill 31,440 units of EPO as 314 billing units).
- If 50 units or more are given, round up to the next 100 units (i.e., bill 31,550 units of EPO as 316 billing units).
- For agency requirements for billing single dose vials, see the *Compliance Packaging* section in the agency's Prescription Drug Program Billing guide.

Where is the fee schedule?

See the agency's Kidney Center Services Fee Schedule.

Billing

All claims must be submitted electronically to the agency, except under limited circumstances. For more information about this policy change, see Paperless Billing at HCA. For providers approved to bill paper claims, see the agency's Paper Claim Billing Resource.

What are the general billing requirements?

Providers must follow the agency's ProviderOne Billing and Resource Guide. These billing requirements include the following:

- Time limits exist for submitting and resubmitting claims and adjustments
- What fee to bill the agency for eligible clients
- When providers may bill a client
- How to bill for services provided to primary care case management (PCCM) clients
- Billing for clients eligible for both Medicare and Medicaid
- Third-party liability claims
- Record- keeping requirements