Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAID PURCHASING ADMINISTRATION
Olympia, Washington

Kidney Center Services

Billing Instructions for Free-Standing and Hospital-Based Kidney Centers

[Chapter 388-540 WAC]

About This Publication

This publication supersedes all previous Department/MPA *Kidney Center Services Billing Instructions* published by the Health and Recovery Services Administration, Washington State Department of Social and Health Services.

Note: The Department now reissues the entire billing manual when making updates, rather than just a page or section. The effective date and revision history are now at the front of the manual. This makes it easier to find the effective date and version history of the manual.

Effective Date

The effective date of this publication is: **1/1/2011**.

2010 Revision History

This publication has been revised by:

Document	Subject	Issue Date	Pages Affected
10-80	Coverage Table and Fee Schedule Changes	December 30, 2010	C.6-C.9

Copyright Disclosure

How Can I Get Department/MPA Provider Documents?

To download and print Department/MPA provider numbered memos and billing instructions, go to the Department/MPA website at http://hrsa.dshs.wa.gov (click the ***Billing Instructions and Numbered Memorandum*** link).

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Important Contacts

Note: This section contains important contact information relevant to kidney center services. For more contact information, see the Department/MPA *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See the Department/MPA *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html
Finding out about payments, denials, claims processing, or Department managed care organizations	
Electronic or paper billing	
Finding Department documents (e.g., billing instructions, # memos, fee schedules)	
Private insurance or third-party liability, other than Department managed care	
How do I obtain prior authorization or a limitation extension?	For all requests for prior authorization or limitation extensions, the following documentation is "required:" • A completed, TYPED ProviderOne request form, DSHS 13-835. This request form MUST be the initial page when you submit your request. • A completed Basic Information Authorization Request Form, DSHS 13-756, and all the documentation listed on this form and any other medical justification. Fax your request to: 1-866-668-1214. See the Department/MPA *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html,

Definitions & Abbreviations

This section defines terms and abbreviations, including acronyms, used in these billing instructions. Please refer to the Department/MPA *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for a more complete list of definitions.

Affiliate - A facility, hospital, unit, business, or person having an agreement with a kidney center to provide specified services to ESRD patients. [WAC 388-540-105]

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. [WAC 388-540-105]

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; and
- Pre- and post-operative dialysis provided to transplant patients.

[WAC 388-540-105]

Benefit Service Package - A grouping of benefits or services applicable to a client or group of clients.

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. [WAC 388-540-105]

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). [WAC 388-540-105]

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. [WAC 388-540-105]

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. [WAC 388-540-105]

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. [WAC 388-540-105]

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. [WAC 388-540-105]

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.
[WAC 388-540-105]

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.
[WAC 388-540-105]

Epoetin Alpha (EPO) - An injectable drug that is a biologically engineered protein that stimulates the bone marrow to make new red blood cells. [WAC 388-540-105]

Free-Standing Kidney Center - A limited care facility, not operated by a hospital, certified by the federal government to provide ESRD services.
[WAC 388-540-105]

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.
[WAC 388-540-105]

Home Dialysis - Refers to any dialysis performed at home. [WAC 388-540-105]

Home Dialysis Helper - A person trained to assist the client in home dialysis.
[WAC 388-540-105]

In-Facility Dialysis - For the purpose of these billing instructions only, in-facility dialysis is dialysis of any type performed on the premises of the kidney center or other free-standing ESRD facility.
[WAC 388-540-105]

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.
[WAC 388-540-105]

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

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

[WAC 388-540-105]

Maintenance Dialysis - The usual periodic dialysis treatments given to a patient who has ESRD. [WAC 388-540-105]

Maximum Allowable - The maximum dollar amount the Department will pay a provider for a specific service, supply, or piece of equipment.

Medical Identification card(s) – See *Services Card*.

National Provider Identifier (NPI) – A system for uniquely identifying all Providers of health care services, supplies, and equipment.

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. [WAC 388-540-105]

ProviderOne – Department of Social and Health Services (the Department) primary provider payment processing system.

ProviderOne Client ID- A system-assigned number that uniquely identifies a single client within the ProviderOne system; the number consists of nine numeric characters followed by WA.
For example: 123456789WA.

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. [WAC 388-540-105]

Services Card – A plastic "swipe" card that the Department issues to each client on a "one- time basis." Providers have the option to acquire and use swipe card technology as one method to access up-to-date client eligibility information.

- The Services Card replaces the paper Medical Assistance ID Card that was mailed to clients on a monthly basis.
- The Services Card will be issued when ProviderOne becomes operational.
- The Services Card displays only the client's name and ProviderOne Client ID number.
- The Services Card does not display the eligibility type, coverage dates, or managed care plans.
- The Services Card does not guarantee eligibility. Providers are responsible to verify client identification and complete an eligibility inquiry.

Transaction Control Number (TCN) - A unique field value that identifies a claim transaction assigned by ProviderOne.

Usual & Customary Fee - The fee that the provider typically charged the general public for the product or service.

About the Program

What Is the Purpose of the Kidney Center Services Program? [WAC 388-540-101]

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

Provider Requirements [WAC 388-540-120]

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

- Be a Medicare-certified ESRD facility;
- Have a signed Core Provider Agreement (CPA) with the Department and meet the requirements in WAC 388-502 Administrative Requirements-Providers. Visit Provider Relations for further information on the CPA (see *Important Contacts*);
- Provide only those services that are within the scope of their provider's license; and
- Provide, 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, including all of the following:
  - ✓ 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; and
  - ✓ Supplies and equipment for home dialysis.

Notifying Clients of Their Rights (Advance Directives)

[42 CFR, Subpart I]

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; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

Client Eligibility

Who Is Eligible? [Refer to WAC 388-540-110 (1)]

To be eligible for the Department's Kidney Center Services program, a client must:

- Be diagnosed with ESRD or acute renal failure; and
- Be covered by a Benefit Service Package (BSP) that covers kidney center services.

> **Note:** Refer to the *Scope of Healthcare Services Table* web page at: http://hrsa.dshs.wa.gov/Download/ScopeofHealthcareSvcsTable.html for an up-to-date listing of Benefit Service Packages.

Please see the Department/MPA *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

Are Clients Enrolled in a Department Managed Care Plan Eligible? [Refer to WAC 388-540-110 (2)]

Yes! The Department managed care enrollees **are eligible** for kidney center services **under their designated plan**. When verifying eligibility using ProviderOne, if the client is enrolled in a Department managed care plan, managed care enrollment will be displayed on the Client Benefit Inquiry screen.

Dialysis services covered under a managed care plan must be obtained by the client through designated facilities or providers. The managed care plan is responsible for:

- Payment of covered services; and
- 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:** To prevent billing denials, please 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 plan. See the Department/MPA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

Primary Care Case Management (PCCM)

For the client who has chosen to obtain care with a PCCM provider, this information will be displayed on the Client Benefit Inquiry screen in ProviderOne. These clients must obtain or be referred for services via a PCCM provider. The PCCM provider is responsible for coordination of care just like the PCP would be in a plan setting.

Note: To prevent billing denials, please 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 PCCM provider. Please see the Department/MPA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

Coverage

What Is Covered? [Refer to WAC 388-540-130]

- The Department covers the following services subject to the restrictions and limitations in these billing instructions and applicable published WAC:

  - ✓ In-facility dialysis;
  - ✓ Home dialysis;
  - ✓ Training for self-dialysis;
  - ✓ Home dialysis helpers;
  - ✓ Dialysis supplies;
  - ✓ Diagnostic lab work;
  - ✓ Treatment for anemia; and
  - ✓ 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 limitations specified by the Department. Providers must obtain a limitation extension (LE) before providing services that exceed specified limits in quantity, frequency, or duration. See the Prior Authorization section for specifics on the LE process.

What Is Not Covered? [Refer to WAC 388-540-140]

The Department does not cover the following in a kidney center:

- Blood and blood products (refer to WAC 388-540-190);
- Personal care items such as slippers, toothbrushes, etc.;
- Additional staff time or personnel costs. Staff time is paid through the composite rate. **Exception: Home dialysis helpers are the only personnel cost paid outside the composite rate (refer to WAC 388-540-160).**

The Department reviews all initial requests for noncovered services based on WAC 388-501-0165.

Services Covered by Other Department Programs

[Refer to WAC 388-540-150 (5-6)]

The following services are covered under other Department programs:

- **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 current Department/MPA *Prescription Drug Program Billing Instructions.*

- **Medical Nutrition** – Only pharmacies or other medical nutrition providers may supply supplemental food products. Bill for these services using the current Department/MPA *Enteral Nutrition Billing Instructions.*

Department/MPA billing instructions may be viewed and downloaded at http://hrsa.dshs.wa.gov (click the ***Billing Instructions and Numbered Memorandum*** link).

Coverage Table

Please note the following items:

- The Department does not pay providers for blood and blood products.
- Payment is limited to blood bank service charges for processing the blood and blood products (refer to WAC 388-550-6500).
- The codes listed below must be used to represent the following costs:

  1) Blood processing and other fees assessed by non-profit blood centers that do not charge for the blood or blood products themselves; or
  2) 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.

Procedure Codes for Blood Processing Used in Outpatient Blood Transfusions

Code Status Indicator	Procedure Code	Blood Processing for Transfusion Description	Policy/ Comments
	P9010	Blood (whole), for transfusion, per unit	
	P9011	Blood (split unit), specify amount	
	P9012	Cryoprecipitate, each unit	
	P9016	Red blood cells, leukocytes reduced, each unit	
	P9017	Fresh frozen plasma (single donor), each unit	
	P9019	Platelets, each unit	
	P9020	Platelet rich plasma, each unit	
	P9021	Red blood cells, each unit	
	P9022	Red blood cells, washed, each unit	
	P9023	Plasma, pooled multiple donor, solvent/detergent treated, frozen, each unit	
	P9031	Platelets, leukocytes reduced, each unit	
	P9032	Platelets, irradiated, each unit	
	P9033	Platelets, leukocytes reduced, irradiated, each unit	
	P9034	Platelets, pheresis, each unit	
	P9035	Platelets, pheresis, leukocytes reduced, each unit	
	P9036	Platelets, pheresis, irradiated, each unit	

Code Status Indicator	Procedure Code	Blood Processing for Transfusion Description	Policy/ Comments
	P9037	Platelets, pheresis, leukocytes reduced, irradiated, each unit	
	P9038	Red blood cells, irradiated, each unit	
	P9039	Red blood cells, deglycerolized, each unit	
	P9040	Red blood cells, leukocytes reduced, irradiated, each unit	
	P9041	Infusion, albumin (human), 5%, 50 ml	
	P9043	Infusion, plasma protein fraction (human), 5%, 50 ml	
	P9044	Plasma, cryoprecipitate reduced, each unit	
	P9045	Infusion, albumin (human), 5%, 250 ml	
	P9046	Infusion, albumin (human), 25%, 20ml	
	P9047	Infusion, albumin (human). 25%, 50ml	
	P9048	Infusion, plasma protein fraction (human), 5%, 250ml	
	P9050	Granulocytes, pheresis, each unit	
	P9054	Whole blood or red blood cells, leukocytes reduced, frozen, deglycerol, washed, each unit	
	P9055	Platelets, leukocytes reduced, cmv-negative, apheresis/pheresis, each unit	
	P9056	Whole blood, leukocytes reduced, irradiated, each unit	
	P9057	Red blood cells, frozen/deglycerolized/washed, leukocytes reduced, irradiated, each unit	
	P9058	Red blood cells, leukocytes reduced, cmv-negative, irradiated, each unit	
	P9059	Fresh frozen plasma between 8-24 hours of collection, each unit	
	P9060	Fresh frozen plasma, donor retested, each unit	

Revenue Codes

Revenue Code	HCPCS Code	Description	Policy/ Comments
Pharmacy			
260		Administration of drugs by IV/intramuscular	(non-renal related and/or not covered by Medicare).
Medical/Surgical Supplies and Devices (Requires specific identification using a HCPCS code)			
270*		Medical/surgical supplies and devices	
Note: In order to receive payment for revenue code 270, the procedure code of the specific supply given must be indicated in field 44 of the UB-04 claim form. Payment is limited to **those supplies listed below**.			
	A4657	Syringe, with or without needle	
	A4750	Blood tubing, arterial or venous, for hemodialysis, each	
	A4913	Miscellaneous dialysis supplies (use for IV tubing, pump)	
Laboratory			
303		Laboratory, renal patient (home)	
304		Laboratory, non-routine dialysis	
Drugs			
Note: Providers must use the correct 11-digit National Drug Code (NDC) when billing the Department for drugs administered to eligible Department clients in kidney centers. See numbered memo 06-06.			
Epoetin Alpha (EPO)			
Note: When billing with revenue codes 634 and 635, each billing unit reported on the claim form represents **100 units** of EPO given.			
634*		Erythropoietin (EPO) less than 10,000 units	
635*		Erythropoietin (EPO) 10,000 or more units	

*** For clients who have dual coverage (Medicare/Medicaid) the asterisked (*) drugs, supplies, and services must first be billed to Medicare.**

Revenue Code	Procedure /HCPCS Code	Description	Admin Dosage	Policy/ Comments
Other Drugs Requiring Specific Identification				
636*		Administration of drugs		Bill number of units based on the description of the drug code)
Note: In order to receive payment for revenue code 636, the procedure code of the specific drug given must be indicated in field 44 of the UB-04 claim form. Payment is limited to **the drugs listed below.**				
	90655	Flu vaccine, preservative free, 6-35 mo, im		
	90656	Flu vaccine, preservative free, 3 yrs & above, im		
	90657	Flu vaccine, 6-35 mo, im		
	90658	Flu vaccine, 3 yrs & above, im		
	90660	Flu vaccine, live, intranasal		
	90732	Pneumococcal vaccine		
	90747	Immunization, active: Hepatitis B vaccine	40 mcg	
	J0280	Injection, Aminophyllin	250 mg	
	J0285	Amphotericin	50 mg	
	J0290	Ampicillin Sodium	500mg	
	J0295	Ampicillin Sodium/Sulbactam sodium	1.5 g	
	J0360	Injection, Hydralazine HCl	20 mg	
	J0530	Penicillin G Benzathine and Procaine	600,000u	
	J0610	Calcium Gluconate	10ml	
	J0630	Calcitonin Salmon	400u	
	J0636	Calcitriol	0.1mcg	
	J0640	Leucovorin Calcium	50 mg	
	J0690	Cefazolin Sodium	500mg	
0636	J0692	Injection, cefepime HCl,	500mg	Effective 1/1/2011
	J0694	Cefoxitin Sodium	1gm	
	J0696	Ceftriaxone Sodium	250mg	
	J0697	Cefuroxime Sodium	750mg	
0636	J0698	Injection, cefotaxime sodium,	per g	Effective 1/1/2011
	J0702	Betamethasone Acetate and Betamethasone Sodium Phosphate	3 mg	
	J0704	Betamethasone Sodium Phosphate	4 mg	
	J0710	Cephapirin Sodium	1gm	
	J0713	Ceftazidime	500 mg	
0636	J0743	Injection, cilastatin sodium; imipenem,	per 250 mg	Effective 1/1/2011

	J0745	Codeine Phosphate	30mg	
636*	J0780	Prochlorperazine	10 mg	
	J0878	Injection, daptomysin,	1 mg	Effective 1/1/2011
	J0895	Deferoxamine Mesylate	500 mg	
	J0970	Estradiol Valerate	40 mg	
	J1060	Testosterone Cypionate and Estradiol Cypionate	1 ml	
	J1070	Testosterone Cypionate	100 mg	
	J1080	Testosterone Cypionate, 1 cc	200 mg	
	J1094	Dexamethasone Acetate	1 mg	
	J1160	Digoxin	0.5 mg	
	J1165	Phenytoin Sodium	50 mg	
	J1170	Hydromorphone	4 mg	
	J1200	Diphenhydramine HCl	50 mg	
	J1240	Dimenhydrinate	50 mg	
	J1270	Injection, doxercalciferol	1 mcg	
	J1335	Injection, ertapenem sodium	500 mg	
	J1580	Gentamicin Sulfate	80 mg	
	J1630	Haloperidol	5 mg	
	J1631	Haloperidol Decanoate	50 mg	
	J1645	Dalteparin Sodium	2500 IU	
	J1720	Hydrocortisone Sodium Succinate	100 mg	
	J1750	Iron Dextran	50 mg	
	J1756	Injection of Iron Sucrose	1 mg	
	J1790	Droperidol	5 mg	
	J1800	Propranolol HCl	1 mg	
	J1840	Kanamycin Sulfate	500 mg	
	J1885	Ketorolac Tromethamine	15 mg	
	J1890	Cephalothin Sodium	1 gm	
	J1940	Furosemide	20 mg	
	J1955	Levocarnitine	1 gm	
	J1956	Injection, levofloxacin	250 mg	
	J1990	Chlordiazepoxide HCl	100 mg	
	J2001	Lidocaine HCl	10 mg	
	J2060	Lorazepam	2 mg	
	J2150	Mannitol 25%	50 ml	
	J2175	Meperidine HCl	100 mg	
	J2185	Injection, meropenem,	100 mg	Effective 1/1/2011

*** For clients who have dual coverage (Medicare/Medicaid) the asterisked (*) drugs, supplies, and services must first be billed to Medicare.**

Revenue Code	Procedure /HCPCS Code	Description	Admin Dosage	Policy/ Comments
Other Drugs Requiring Specific Identification (Continued)				
636*	J2270	Morphine Sulfate	10 mg	
	J2275	Morphine Sulfate (sterile solution)	10 mg	
	J2320	Nandrolone Decanoate	50 mg	
	J2321	Nandrolone Decanoate	100 mg	
	J2322	Nandrolone Decanoate	200 mg	
	J2501	Paricalcitol	1 mcg	
	J2510	Penicillin G Procaine Aqueous	600,000u	
	J2540	Penicillin G Potassium	600,000u	
	J2550	Promethazine HCl	50mg	
	J2560	Phenobarbital Sodium	120mg	
	J2690	Procainamide HCl	1gm	
	J2700	Oxacillin Sodium	250mg	
	J2720	Protamine Sulfate	10mg	
	J2765	Metoclopramide HCl	10mg	
	J2800	Methocarbamol	10 ml	
	J2916	Sodium Ferric Gluconate Complex in Sucrose Injection	12.5mg	
	J2920	Methylprednisolone Sodium Succinate	40 mg	
	J2930	Methylprednisolone Sodium Succinate	125 mg	
	J2995	Streptokinase	250,000 IU	
	J2997	Alteplase Recombinant	1 mg	
	J3000	Streptomycin	1gm	
	J3010	Fentanyl Citrate	0.1mg	
	J3070	Pentazocine HCl	30mg	
	J3120	Testosterone Enanthate	100mg	
	J3130	Testosterone Enanthate	200mg	
	J3230	Chlorpromazine HCl	50mg	
	J3250	Trimethobenzamide HCl	200mg	
	J3260	Tobramycin Sulfate	80mg	
	J3280	Thiethylperazine Maleate	10mg	
	J3301	Triamcinolone Acetonide	10 mg	
	J3360	Diazepam	5mg	
	J3364	Urokinase	5,000 IU vial	

Revenue Code	Procedure /HCPCS Code	Description	Admin Dosage	Policy/ Comments
Other Drugs Requiring Specific Identification (Continued)				
636*	J7500	Azathioprine, oral	50 mg	Effective 1/1/2011
	J7502	Cyclosporine, oral	100 mg	Effective 1/1/2011
	J7506	Prednisone, oral	per 5 mg	Effective 1/1/2011
	J7507	Tacrolimus, oral	per 1 mg	Effective 1/1/2011
	J7515	Cyclosporine, oral	25 mg	Effective 1/1/2011
	J7517	Mycophenolate mofetil, oral	250 mg	Effective 1/1/2011
	J7518	Mycophenolic acid, oral,	180 mg	Effective 1/1/2011
	J7520	Sirolimus, oral,	1 mg	Effective 1/1/2011

*** For clients who have dual coverage (Medicare/Medicaid) the asterisked (*) drugs, supplies, and services must first be billed to Medicare.**

Revenue Code	Procedure /HCPCS Code	Description	Admin Dosage	Policy/ Comments
Other Drugs Requiring Specific Identification (Continued)				
636*	J3365	IV Urokinase	250,000 IU vial	
	J3370	Vancomycin HCl	500 mg	
	J3410	Hydroxyzine HCl	25 mg	
	J3420	Vitamin B-12 Cyanocobalamin	1,000 mcg	
	J3430	Phytonadione (Vitamin K)	1mg	
	J3490	Unclassified Drugs		
Note: The National Drug Code (NDC) number, and dosage given to the client must be included in the remarks section of the claim form when billing unlisted drug HCPCS code J3490.				
	Q4054	Darbepoetin alfa	1mcg	
EKG/ECG (Electrocardiogram) – Technical Portion Only				
730*		General classification		
Hemodialysis – Outpatient or Home				
821*		Hemodialysis/composite rate.		Limited to 14 per client, per month. **(Do not bill in combination with 831, 841, 851, or 880.)**
825		Support Services		(Home Helper)
Intermittent Peritoneal Dialysis – Outpatient or Home				
831*		Peritoneal dialysis/Composite Rate.		Limited to 14 per client, per month. **(Do not bill in combination with 821, 841, 851, or 880.)**
835		Support Services		(Home Helper)
Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient or Home				
841*		CAPD/Composite Rate.		Limited to 31 per client, per month. **(Do not bill in combination with 821, 831, 851, or 880.)**
845		Support Services		(Home Helper)

*** For clients who have dual coverage (Medicare/Medicaid) the asterisked (*) drugs, supplies, and services must first be billed to Medicare.**

Revenue Code	Procedure /HCPCS Code	Description	Admin Dosage	Policy/ Comments
Continuous Cycling Peritoneal Dialysis (CCPD) - Outpatient or Home				
851		CCPD/Composite Rate.		Limited to 31 per client, per month. **(Do not bill in combination with 821, 831, 841, or 880.)**
855		Support Services		(Home Helper)
Miscellaneous Dialysis				
880		General Classification.		Limited to 14 per client, per month. **(Do not bill in combination with 821, 831, 841, or 851.)**
881		Ultrafiltration		

*** For clients who have dual coverage (Medicare/Medicaid) the asterisked (*) drugs, supplies, and services must first be billed to Medicare.**

Prior Authorization

[Refer to WAC 388-531-0200]

Is Prior Authorization Required?

Yes. Prior authorization is required through a limitation extension.

Note: Please see the Department/MPA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for more information on requesting authorization.

Limitation Extensions

What is a Limitation Extension?

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

Limitation Extensions 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.

How do I get LE authorization?

Obtain an LE by using the written/fax authorization process below.

Written/Fax Authorization

What is written/fax authorization?

Written or fax authorization is the paper authorization process providers must use when requesting an LE.

How do I obtain written/fax authorization?

Send or fax a completed Fax/Written Request Basic Information, DSHS 13-756, to the Department-MPA Medical Request Coordinator (see the *Important Contacts* section). This form can be downloaded from the Department's web site at: http://www1.dshs.wa.gov/msa/forms/eforms.html.

Payment

How Does the Department Pay for Kidney Center Services?
[Refer to WAC 388-540-150]

The Department of Social & Health Services (the Department) recognizes a free-standing kidney center as an outpatient facility. The Department pays free-standing kidney centers for providing kidney center services to Department clients using one of the following payment methods:

- **Composite rate payments** - 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 system.

  - ✓ 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 Fee Schedule.

- **Noncomposite rate payments** – ESRD services and items covered by the Department, but not included in the composite rate, are billed and paid separately. This methodology uses a maximum allowable fee schedule to pay providers (see "*What is not included in the composite rate?"* for more detail on noncomposite rate payments).

What Is Included in the Composite Rate? [WAC 388-540-160]

The following equipment, supplies, and services for in-facility and home dialysis are included in a composite rate:

- Medically necessary dialysis equipment;
- All 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 and the administration of oxygen;
- Staff time used to administer blood and nonroutine parenteral items;
- Non-invasive vascular studies; and
- Training for self-dialysis and home dialysis helpers.

The Department 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 Department does not pay for any part of the items and services that were furnished.

How Many Dialysis Sessions Are Allowed?
[WAC 388-540-150 (1)(b) and (c)]

The Department pays providers for the following number of dialysis sessions:

- For revenue codes 821, 831, and 880, a maximum of 14 per client, per month.
- For revenue codes 841 and 851, a maximum of 31 per client, per month.

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

What Is Not Included in the Composite Rate? [WAC 388-540-170]

The following supplies and services are **not** included in the composite rate and may be billed separately, subject to the restrictions or limitations in these billing instructions and applicable published WAC:

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

  ✓ Be prescribed by a physician; and
  ✓ Meet the rebate requirements described in WAC 388-530-1125; and
  ✓ 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 "Blood Products and Services").

- Home dialysis helpers.

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

Laboratory Services [Refer to WAC 388-540-180]

- 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-9CM 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
	CAPD Tests: Albumin BUN Calcium CO2 Creatinine Dialysate Protein HCT HGB LDH Magnesium Alkaline 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.)
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.

Blood Products and Services **[Refer to WAC 388-540-190]**

The Department 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; and

- Costs, up to the Department's maximum allowable fee, incurred by the center to administer its in-house blood procurement program.

The Department does not pay free-standing kidney centers for blood or blood products (refer to WAC 388-550-6500).

Staff time used to administer blood or blood products is included in the payment for the composite rate (refer to WAC 388-540-150 and 388-540-160).

Epoetin Alpha (EPO) [Refer to WAC 388-540-200]

The Department pays the kidney center for EPO therapy when:

- Administered in the kidney center to a client:
  - ✓ With a hematocrit less than 33 percent or a hemoglobin less than 11 when therapy is initiated; or
  - ✓ Continuing EPO therapy with a hematocrit between 30 and 36 percent.
- Provided to a home dialysis client:
  - ✓ With a hematocrit less than 33 percent or a hemoglobin less than 11 when therapy is initiated; and
  - ✓ When permitted by Washington Board of Pharmacy Rules (refer to 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).

Fee Schedule

You may view the Department/MPA **Kidney Center Services Fee Schedule** on-line at

http://hrsa.dshs.wa.gov/RBRVS/Index.html

Billing and Claim Forms

What Are the General Billing Requirements?

Providers must follow the Department/MPA *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html. These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments;
- What fee to bill the Department 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; and
- Record keeping requirements.

Completing the UB-04 Claim Form

Detailed instructions on how to complete and bill according to the official UB-04 Data Specifications Manual is available from the National Uniform Billing Committee at: http://www.nubc.org/index.html.

For more information, read # Memo 06-84.