Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Health and Recovery Services Administration (HRSA)

Kidney Center Services

Billing Instructions For Free-Standing Kidney Centers

[Chapter 388-540 WAC]

Copyright disclosure

About this publication

This publication supersedes all previous HRSA Kidney Center Services Program Billing Instructions and Numbered Memorandum 03-48 MAA, 04-12 MAA, 04-26 MAA, 04-38 MAA, 05-50, 05-48 and 06-98.

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Note: The effective date and publication date for any particular page of this document may be found at the bottom of the page.

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Important Contacts

A provider may use HRSA's toll-free lines for questions regarding its programs; however, HRSA's response is based solely on the information provided to the [HRSA] representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern HRSA's programs.
[WAC 388-502-0020(2)].

Where do I call for information to become a DSHS provider, to submit a change of address or ownership, or to ask questions about the status of a provider application?

Provider Enrollment Unit
866.545.0544 (Select option #1)

Where do I send my claims?

Division of Medical Benefits and Care Management
PO Box 9246
Olympia, WA 98507-9246

How do I obtain copies of billing instructions or numbered memoranda?

Go to HRSA's web site at: http://maa.dshs.wa.gov, Provider Publications/Fee Schedules link.

Who do I contact if I have questions regarding…

Policy, payments, denials, general questions regarding claims processing, Healthy Options, or to request billing instructions?

Provider Relations
800.562.3022 (Select option #2)

Prior Authorization?

Division of Medical Benefits and Care Management
PO Box 45506
Olympia, WA 98504-5506
360.586.1471 Fax

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits
800.562.6136

Electronic Billing?

Electronic Media Claims Help Desk
360.725.1267

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Definitions & Abbreviations

This section defines terms and abbreviations (includes acronyms) used in these billing instructions.

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 reimbursement 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]

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]

Client – An individual who has been determined eligible to receive medical or health care services under any HRSA program.

Code of Federal Regulations (CFR) – Rules adopted by the federal government.

Community Services Office(s) (CSO) - An office of the department which administers social and health services at the community level. [WAC 388-500-0005]

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]

Core Provider Agreement - The basic contract between the Medical Assistance Administration (HRSA) and an entity providing services to eligible HRSA clients. The core provider agreement outlines and defines terms of participation in Medical Assistance.

Department - The state Department of Social and Health Services (DSHS). [WAC 388-500-0005]

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]

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medical Benefits (EOMB) – A federal report generated by Medicare for its providers that displays transaction information regarding Medicare claims processing and payments.

Fee-For-Service – A payment method HRSA uses to reimburse providers for covered medical services provided to medical assistance clients, except those services provided under HRSA's prepaid managed care programs.

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]

Health and Recovery Services Administration (HRSA) - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI State Children's Health Insurance Program (SCHIP), Title XVI Supplemental Security Income for the Aged, Blind, and Disabled (SSI), and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities.

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]

Managed Care – A comprehensive system of coordinated medical and health care delivery including preventive, primary, specialty, and ancillary health services. [WAC 388-538-050]

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

Medicaid - The state and federally funded Title IX program under which medical care is provided to persons eligible for the Categorically Needy (CNP) Program or Medically Needy (MNP) Program.

Medical Identification (ID) card – The document that identifies a client's eligibility for a medical program. This card was formerly known as the medical assistance identification (MAID) card or medical coupon.

Medically Necessary - A term for describing [a] requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. [WAC 388-500-0005]

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each HRSA client and that consists of:

- First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

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]

Provider – Any person or organization that has a signed contract or Core Provider Agreement with DSHS to provide services to eligible clients.

Remittance and Status Report (RA) - A report produced by the Medicaid Management Information System (MMIS), HRSA's claims processing system, that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) - Washington State laws.

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]

Third Party – Any entity that is or may be liable to pay all or part of the medical cost of care of a medical program client.

Title XIX - The portion of the Federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. [WAC 388-500-0005]

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

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

About the Program

What is the purpose of the Kidney Center Services program? [WAC 388-540-101]

The purpose of the Health and Recovery Services Administration (HRSA) 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 reimbursement from HRSA for providing care to HRSA clients, a kidney center must:

- Be a Medicare-certified ESRD facility;
- Have a signed Core Provider Agreement (CPA) with HRSA and meet the requirements in WAC 388-502 Administrative Requirements-Providers (visit Provider Relations for further information on the CPA);
- 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 HRSA's Kidney Center Services program, a client must:

- Be diagnosed with ESRD or acute renal failure; and
- Present a current Medical Identification (ID) card with one of the following identifiers:

Medial Identification Card Identifier	Medical Program
CNP	Categorically Needy Program
CNP-CHIP	Categorically Needy Program - Children's Health Insurance Program
CNP Emergency Medical Only	Categorically Needy Program - Emergency Medical Only
MIP-EMER Hospital No-out-of-state care	Medically Indigent Program (Hospital-based services only)
GA-U No Out of State Care	General Assistance - Unemployable
LCP-MNP	Limited Casualty Program-Medically Needy Program

Note: Clients presenting a Medical ID card with the **MIP-EMER Hospital No-out-of-state care (Medically Indigent Program)** identifier are not eligible for the Kidney Center Services program.

* HRSA reimburses providers for a client presenting a Medical ID Card with a QMB-Medicare Only identifier for that client's deductible and coinsurance if Medicare has made payment (refer to page G.3).

Are clients enrolled in managed care eligible for Kidney Center Services? [Refer to WAC 388-540-110 (2)]

Yes! HRSA managed care enrollees **are eligible** for Kidney Center services **under their designated plan**. Dialysis services must be arranged directly through the client's managed care plan. An identifier in the Health Maintenance Organization (HMO) column on the client's DSHS Medical ID card indicates that the client is enrolled in an HRSA managed care plan. The client's plan covers hemodialysis, or other appropriate procedures to treat renal failure, including equipment needed in the course of treatment.

To prevent billing denials, please check the client's Medical ID card **prior** to scheduling services and at the **time of service** to make sure proper authorization or referral is obtained from the PCP and plan.

Primary Care Case Management (PCCM)

For the client who has chosen to obtain care with a PCCM, the identifier in the HMO column will be "PCCM." These clients must obtain, or be referred for, services via the PCCM. The PCCM is responsible for coordination of care just like the PCP would be in a plan setting. Please refer to the client's Medical ID card for the PCCM. (See the *Billing* section for further information.)

> **Note:** To prevent billing denials, please check the client's Medical ID card **prior** to scheduling services and at the **time of the service** to make sure you obtain proper authorization or referral from the PCCM.

Coverage

What is covered? [Refer to WAC 388-540-130]

- HRSA 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 HRSA. 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]

HRSA 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).**

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

Services Covered by Other HRSA Programs

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

The following services are covered under other HRSA 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 HRSA's *Prescription Drug Program Billing Instructions.*

- **Medical Nutrition** – Only pharmacies or other medical nutrition providers may supply supplemental food products. Bill for these services using HRSA's *Medical Nutrition Billing Instructions.*

HRSA's billing instructions may be viewed and downloaded at http://maa.dshs.wa.gov. Click **Provider Publications/Fee Schedules** link.

Kidney Services Coverage Table

Please note the following items:

- HRSA does not reimburse providers for blood and blood products.
- Reimbursement 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. Reimbursement 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	
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. Reimbursement is limited to **those 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	
	J0694	Cefoxitin Sodium	1gm	
	J0696	Ceftriaxone Sodium	250mg	
	J0697	Cefuroxime Sodium	750mg	
	J0702	Betamethasone Acetate and Betamethasone Sodium Phosphate	3 mg	
	J0704	Betamethasone Sodium Phosphate	4 mg	
	J0710	Cephapirin Sodium	1gm	
	J0713	Ceftazidime	500 mg	
	J0745	Codeine Phosphate	30mg	

*** 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*	J0780	Prochlorperazine	10 mg	
	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	
	J2270	Morphine Sulfate	10 mg	
	J2275	Morphine Sulfate (sterile solution)	10 mg	

*** 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*	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	
	J3365	IV Urokinase	250,000 IU vial	
	J3370	Vancomycin HCl	500 mg	
	J3410	Hydroxyzine HCl	25 mg	

*** 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*	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]

Prior Authorization

Is prior authorization required for Kidney Center Services?

Yes. Prior authorization is required through a limitation extension.

Limitation Extensions

What is a Limitation Extension?

A limitation extension (LE) is HRSA's authorization for the provider to furnish more units of service than are allowed in WAC and HRSA's 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 your request to the HRSA Medical Request Coordinator (see *Important Contacts*) You must include the basic information contained in the sample fax/written request form on the next page. The sample form is provided for your convenience - its use is not mandatory, but you must include the information requested on this form when you request an LE.

Fax/Written Request Basic Information

Provider Information

Name _____ Provider #: _____

Phone _____ Fax: _____

Client Information

Name _____ PIC# - - -

i.e. (AB-122300-SMITH-A)

Service Request Information

Description of service being requested: _____

_____

Revenue Code _____ Number of units requested _____

Medical Information

Diagnosis code _____ Diagnosis name _____

Place of service _____

What is the clinical justification for this request (for clients needing more than 14 dialysis sessions per month, please give the medical reason)?

_____

_____

_____

Please send in any necessary additional documentation with your request to:

Fax: **360.586.1471** or mail to: Medical Request Coordinator
Division of Healthcare and Service Delivery
PO Box 45506
Olympia, WA 98504-5506

Reimbursement

How does HRSA reimburse for kidney center services?
[Refer to WAC 388-540-150]

The Medical Assistance Administration (HRSA) recognizes a free-standing kidney center as an outpatient facility. HRSA reimburses free-standing kidney centers for providing kidney center services to HRSA 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 reimbursed 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 HRSA, but not included in the composite rate, are billed and paid separately. This methodology uses a maximum allowable fee schedule to reimburse 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" on page E.3);
- 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.

HRSA 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, HRSA 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)]

HRSA reimburses 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" on page E.5).

- 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 reimbursed 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

Frequency of Testing Under ESRD Composite Rate	Standard ESRD Test
	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 reimbursed to, the laboratory that performs the test.

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

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

HRSA does not reimburse 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 reimbursement for the composite rate (refer to WAC 388-540-150 and 388-540-160).

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

HRSA reimburses 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 HRSA's **Kidney Center Services Fee Schedule** on-line at

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

For a paper copy of the fee schedule:

- **Go to:** http://www.prt.wa.gov/ (On-line orders filled daily.) Click **General Store**. Follow prompts to **Store Lobby** → Search by **Agency** → **Department of Social and Health Services** → **Health and Recovery Services Administration** → desired document; **or**

- **Fax/Call:** Dept. of Printing/Attn: Fulfillment at FAX 360.586.6361/ telephone 360.586.6360. (Faxed or telephoned orders may take up to 2 weeks to fill.)

Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

HRSA has two timeliness standards for: 1) initial claims; and 2) resubmitted claims.

- **Initial Claims**

  - ✓ HRSA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:

    - The date the provider furnishes the service to the eligible client;
    - The date a final fair hearing decision is entered that impacts the particular claim;
    - The date a court orders HRSA to cover the services; or
    - The date DSHS certifies a client eligible under delayed[1] certification criteria.

  - ✓ HRSA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

    - DSHS certification of a client for a retroactive[2] period; or
    - The provider proves to HRSA's satisfaction that there are extenuating circumstances.

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[1] **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill HRSA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill HRSA for the service.

[2] **Retroactive Certification -** According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill HRSA for the service.

- **Resubmitted Claims**

  Providers may **resubmit, modify, or adjust** any timely initial claim, **except** prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

  Note: HRSA does not accept any claim for resubmission, modification, or adjustment after the time period listed above.

- The time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to HRSA by claim adjustment. The provider must refund overpayments to HRSA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  ✓ The provider fails to meet these listed requirements; and
  ✓ HRSA does not pay the claim.

What fee should I bill HRSA for eligible clients?

Bill HRSA your usual and customary fee**.**

How do I bill for services provided to Primary Care Case Management (PCCM) clients?

When billing for services provided to PCCM clients:

- Enter the referring physician or PCCM name in form locator #83 on the UB-04 claim form; and
- Enter the seven-digit, HRSA-assigned identification number of the PCCM who referred the client for the service(s). If the client is enrolled with a PCCM and the PCCM referral number is not in form locator #83 when you bill HRSA, the claim will be denied.

How do I bill for clients who are eligible for both Medicare and Medicaid?

If a client is eligible for both Medicare and Medicaid, **you must *first* submit a claim to Medicare and accept assignment within Medicare's time limitations**. HRSA may make an additional payment after Medicare reimburses you.

- If Medicare pays the claim, the provider must bill HRSA within six months of the date Medicare processes the claim.

- If Medicare denies payment of the claim, HRSA requires the provider to meet HRSA's initial 365-day requirement for initial claims.

QMB (Qualified Medicare Beneficiaries) Program Limitations:

QMB with CNP or MNP (Qualified Medicare Beneficiaries with Categorically Needy Program or Medically Needy Program)

(Clients who have CNP or MNP identifiers on their medical ID card in addition to QMB)

- If Medicare **and** Medicaid cover the services, HRSA will pay only the deductible and/or coinsurance up to Medicare's or Medicaid's allowed amount, whichever is less.

- If only Medicare **and not Medicaid** covers the service, HRSA will pay only the deductible and/or coinsurance up to Medicare's allowed amount.

- If only Medicaid **and not Medicare** covers the service and the service is covered under the CN or MN program, HRSA will reimburse for the service.

QMB-Medicare Only

The reimbursement criteria for this program are as follows:

- If Medicare **and** Medicaid cover the service, HRSA will pay only the deductible and/or coinsurance up to Medicare's or Medicaid's allowed amount, whichever is less.

- If only Medicare **and not Medicaid** covers the service, HRSA will pay only the deductible and/or coinsurance up to Medicare's allowed amount.

- If **Medicare does not** cover the service, HRSA will not reimburse the service.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's DSHS Medical ID Card. An insurance carrier's time limit for claim submissions may be different. It is your responsibility to meet HRSA's and the insurance carrier's requirements relating to billing time limits, prior to any payment by HRSA.

You must meet HRSA's 365-day billing time limit even if you have not received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding HRSA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by HRSA, or if you have reason to believe that HRSA may make an additional payment:

- Submit a completed claim form to HRSA;
- Attach the insurance carrier's statement;
- If rebilling, also attach a copy of the HRSA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on the Internet at http://maa.dshs.wa.gov, or by calling the Coordination of Benefits at 800.562.6136.

What records must be kept? [Refer to WAC 388-502-0020]

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications (including NDC numbers), equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, **for at least six years from the date of service** or more if required by federal or state law or regulation.

A provider may contact HRSA with questions regarding HRSA's programs. However, HRSA's response is based solely on the information provided to HRSA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern HRSA's programs. (Refer to WAC 388-502-0020[2])

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UB-04 Claim Form

Attention! HRSA accepts only the new UB-04 Claim Form.

- **On March 1, 2007**, HRSA began accepting both the new UB-04 and the old UB-92 claim forms.
- **As of May 23, 2007**, HRSA accepts only the new UB-04 claims form. HRSA will return all claims submitted on the UB-92 claim forms.

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 # Memorandum 06-84.

To see a sample of the UB-04 Claim Form, see the *General Information Booklet*.

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