Kidney Center Services
Provider Guide

July 1, 2014

About this guide[1]

This publication takes effect July 1, 2014, and supersedes earlier guides to this program.

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
Procedure codes	Added HCPCS codes J7508 and J7527 to the Revenue codes section. The agency began covering these procedure codes on January 1, 2014, and added them to the fee schedule, but not to the provider guide.	To match the agency's Kidney Center Services Fee Schedule
Billing	Added a reference to the agency's *Prescription Drug Program Provider Guide*.	To help providers find agency requirements for billing single dose vials

How can I get agency provider documents?

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

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[1] This publication is a billing instruction.

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Definitions

This list defines terms and abbreviations, including acronyms, used in this Medicaid provider guide. See the agency's Medical Assistance Glossary 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.

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 when 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.

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

(42 CFR, Part 489, Subpart I)

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.

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Client Eligibility

(WAC 182-540-110(1))

How can I verify a patient's eligibility?

Providers must verify that a patient has Washington 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.

Verifying eligibility is a two-step process:

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

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

Step 2. **Verify service coverage under the Washington Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Washington Apple Health client's benefit package, see the agency's Health Care Coverage—Program Benefit Packages and Scope of Service Categories web page.

Note: Patients who are not Washington 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.

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

(WAC 182-540-110(2))

Yes. The agency's managed care enrollees **are eligible** for kidney center services **under their designated plan**. When verifying eligibility using ProviderOne, if the client is enrolled in an agency 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.
- 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, 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 agency's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

Are Primary Care Case Management (PCCM) clients covered?

Yes. 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, 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. See the agency's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

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Coverage

What is covered?

(WAC 182-540-130)

- 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 published 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 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.

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What types of services 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 Medicaid Provider Guide.

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

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Coverage Table

What is not covered?

The agency does not cover or pay for blood and blood products.

What is covered?

- The agency covers and pays for only the blood bank service charge for processing the blood and blood products (see WAC 182-550-6500).
- 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.

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

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	Plasma 1 donor frz w/in 8 hr	
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	

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HCPCS Code	Short Descriptions	Policy/ Comments
P9036	Platelet pheresis irradiated	
P9037	Plate pheres leukoredu irrad	
P9038	RBC irradiated	
P9039	RBC deglycerolized	
P9040	RBC leukoreduced irradiated	
P9041	Albumin (human), 5%, 50ml	
P9043	Plasma protein fract,5%,50ml	
P9044	Cryoprecipitatereducedplasma	
P9045	Albumin (human), 5%, 250 ml	
P9046	Albumin (human), 25%, 20 ml	
P9047	Albumin (human), 25%, 50ml	
P9048	Plasmaprotein fract,5%,250ml	
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	

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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 HCPS 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**.			
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 (use for IV tubing, pump)	
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	

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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 field 44 of the UB-04 claim form. 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	90655	Flu vac no prsv 3 val 6-35 m		
0636	90656	Flu vaccine no preserv 3 & >		
0636	90657	Flu vaccine 3 yrs im		
0636	90658	Flu vaccine 3 yrs & > im		
0636	90660	Flu vaccine nasal		
0636	90673	Flu vaccine no preserv im		
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	500mg	
0636	J0295	Ampicillin sodium per 1.5 gm	1.5 g	
0636	J0360	Hydralazine hcl injection	20 mg	
0636	J0610	Calcium gluconate injection	10ml	
0636	J0630	Calcitonin salmon injection	400u	
0636	J0636	Inj calcitriol per 0.1 mcg	0.1mcg	
0636	J0640	Leucovorin calcium injection	50 mg	
0636	J0690	Cefazolin sodium injection	500mg	
0636	J0692	Cefepime HCl for injection	500mg	
0636	J0694	Cefoxitin sodium injection	1gm	
0636	J0696	Ceftriaxone sodium injection	250mg	
0636	J0697	Sterile cefuroxime injection	750mg	
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	J0745	Inj codeine phosphate /30 MG	30mg	
0636	J0780	Prochlorperazine injection	10 mg	
0636	J0878	Daptomycin injection	1 mg	
0636	J0882	Darbepoetin alfa, esrd use	1mcg	
0636	J0895	Deferoxamine mesylate inj	500 mg	

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Revenue Code	Procedure Code	Short Description		Policy/ Comments
0636	J0970	Estradiol valerate injection	40 mg	
0636	J1060	Testosterone cypionate 1 ML	1 ml	
0636	J1070	Testosterone cypionat 100 MG	100 mg	
0636	J1080	Testosterone cypionat 200 MG	200 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	J2275	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	50mg	

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Revenue Code	Procedure Code	Short Description		Policy/ Comments
0636	J2560	Phenobarbital sodium inj	120mg	
0636	J2690	Procainamide hcl injection	1gm	
0636	J2700	Oxacillin sodium injection	250mg	
0636	J2720	Inj protamine sulfate/10 MG	10mg	
0636	J2765	Metoclopramide hcl injection	10mg	
0636	J2800	Methocarbamol injection	10 ml	
0636	J2916	Na ferric gluconate complex	12.5mg	
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	1gm	
0636	J3010	Fentanyl citrate injection	0.1mg	
0636	J3070	Pentazocine injection	30mg	
0636	J3120	Testosterone enanthate inj	100mg	
0636	J3130	Testosterone enanthate inj	200mg	
0636	J3230	Chlorpromazine hcl injection	50mg	
0636	J3250	Trimethobenzamide hcl inj	200mg	
0636	J3260	Tobramycin sulfate injection	80mg	
0636	J3280	Thiethylperazine maleate inj	10mg	
0636	J3301	Triamcinolone acet inj NOS	10 mg	
0636	J3360	Diazepam injection	5mg	
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 50mg	50 mg	
0636	J7502	Cyclosporine oral 100 mg	100 mg	
0636	J7506	Prednisone oral	per 5 mg	
0636	J7507	Tacrolimus oral per 1 MG	per 1 mg	
0636	J7508	Tacrolimus ex rel oral 0.1mg	0.1 mg	Effective 1/1/2014
0636	J7515	Cyclosporine oral 25 mg	25 mg	
0636	J7517	Mycophenolate mofetil oral	250 mg	
0636	J7518	Mycophenolic acid	180 mg	

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Revenue Code	Procedure Code	Short Description		Policy/ Comments
0636	J7520	Sirolimus, oral	1 mg	
0636	J7527	Oral everolimus	0.25 mg	Effective 1/1/2014
0636	J3490	Drugs unclassified injection		
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.				
	Q2034	Agriflu vaccine		Ages 19 and older
	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		Hemodialysis/composite rate.		Limited to 14 per client, per month. **(Do not bill in combination with 831, 841, or 851.)**
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		CCPD/Composite Rate.		Limited to 31 per client, per month. **(Do not bill in combination with 821, 831, or 841.)**
0855		Support Services		(Home Helper)

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Authorization

(WAC 182-531-0200)

What is a limitation extension (LE)?

An LE is the agency's authorization for the provider to furnish more units of service than are allowed in WAC and agency Medicaid provider 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 (PA) required for an LE?

Yes. Prior authorization (PA) is required for an LE.

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

How do I get LE authorization?

You can obtain an LE by using the written or fax authorization process below.

What is written or fax authorization?

Written or fax authorization is the paper authorization process providers must use when submitting a request for an LE.

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How is written or fax authorization requested?

To receive PA or an LE from the agency, 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**.

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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** – 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 What is not included in the composite rate? for more detail on noncomposite rate payments).

Note: The agency recognizes a free-standing kidney center as an outpatient facility.

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.

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- 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.

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- Blood processing fees charged by the blood bank (see Does the agency pay free-standing kidney centers for blood products and services?).

- Home dialysis helpers.

The above items are subject to the restrictions or limitations in this provider guide and applicable published 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-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

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Frequency of Testing Under ESRD Composite Rate	Standard ESRD Test
	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.)
	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.

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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)

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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, please see the *Compliance Packaging* section in the agency's Prescription Drug Program Provider Guide.

Where is the fee schedule?

See the agency's Kidney Center Services Fee Schedule.

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Billing and Claim Forms

What are the general billing requirements?

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

- What time limits exist for submitting and resubmitting claims and adjustments
- When providers may bill a client
- How to bill for services provided to primary care case management (PCCM) clients
- How to bill for clients eligible for both Medicare and Medicaid
- How to handle third-party liability claims
- What standards to use for record keeping

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.

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