To: Federally Qualified Health Centers
   Nurse Practitioners
   Physician Assistants
   Physician Clinics
   Physicians
   Rural Health Clinics

To: HMOs and Other Managed Care Programs

Code Changes for End-Stage Renal Disease-Related Services

Effective for dates of service (DOS) on and after January 1, 2004, Wisconsin Medicaid adopted new Healthcare Common Procedure Coding System (HCPCS) procedure codes for end-stage renal disease (ESRD)-related services. Effective for DOS on and after October 1, 2004, Current Procedural Terminology (CPT) codes will no longer be accepted for ESRD-related services; however, providers may submit claims with either CPT or HCPCS procedure codes for DOS before October 1, 2004.

New Procedure Codes for End-Stage Renal Disease-Related Services

Effective for dates of service (DOS) on and after January 1, 2004, providers may submit claims with Healthcare Common Procedure Coding System (HCPCS) procedure codes in the range of G0308-G0327 for professional end-stage renal disease (ESRD)-related services. These codes replace Current Procedural Terminology (CPT) codes in the range of 90918-90925 for professional ESRD-related services provided by physicians, physician clinics, nurse practitioners, physician assistants, and rural health clinics.

Providers may submit claims with either CPT or HCPCS procedure codes for DOS before October 1, 2004, for ESRD-related services; however, for DOS on and after October 1, 2004, providers will be required to indicate HCPCS procedure codes on claims. Wisconsin Medicaid will no longer reimburse CPT procedure codes on claims for ESRD-related services for DOS on and after October 1, 2004; these claims will be denied. Refer to Attachment 1 of this Wisconsin Medicaid and BadgerCare Update for the procedure code conversion chart. Refer to the HCPCS procedure code book for complete procedure code descriptions.

The new HCPCS procedure codes may be reimbursed once per calendar month per recipient. The codes are included on the physician’s maximum allowable fee schedule which is located on the Wisconsin Medicaid Web site at dhfs.wisconsin.gov/medicaid/. Recipient copayments will be deducted from these procedure codes as appropriate.

Billing Requirements

Procedure Codes G0308-G0319

Procedure codes G0308-G0319 are for ESRD recipients who are receiving dialysis treatment somewhere other than in their home, based on the age of the recipient and the number of face-to-face visits. The visits may occur in the physician’s office, an outpatient hospital or other outpatient setting, or the recipient’s home, as well as the dialysis facility. If the visits occur in multiple locations, providers should indicate on
claims the place of service code where most of the visits occurred.

These procedure codes are based on per month services. Consequently, for ESRD recipients who are hospitalized during the month, the physician may bill the code that reflects only the number of face-to-face visits that occurred during the month on days when the recipient was not in the hospital.

When billing for these procedure codes, report the first DOS in the month in Element 24A of the CMS 1500 claim form. Always indicate a “1.0” in Element 24G to represent a month of care. Do not report the specific dates of each dialysis session. Refer to Attachment 2 for a sample claim form.

*Procedure Codes G0320-G0323*

Procedure codes G0320-G0323 are for home dialysis ESRD recipients. They differ according to age, but do not specify the frequency of required visits with the physician throughout the month. These procedure codes are based on per month services.

When billing for these procedure codes, report the first DOS of the month in Element 24A of the CMS 1500 claim form. Always indicate a “1.0” in Element 24G to represent a month of care. Do not report the specific dates of each dialysis session. Refer to Attachment 3 for a sample claim form.

*Procedure Codes G0324-G0327*

Procedure codes G0324-G0327 are for home dialysis ESRD recipients that are hospitalized during the month.

These procedure codes can be used to report daily management for the days the recipient is not in the hospital. For example, if a home dialysis recipient is in the hospital for 10 days and is cared for at home the other 20 days during the month, then 20 units of one of the codes would be used. If a home dialysis recipient receives dialysis in a dialysis center or other facility during the month, the physician is still paid the management fee and may not bill procedure codes G0308-G0319.

When billing for these procedure codes, report the DOS for ESRD-related care within a calendar month, with the first DOS as the “From DOS” and the last DOS as the “To DOS” in Element 24A. Providers submitting paper claims may indicate up to four DOS per detail line. Indicate the actual number of days under the physician’s care within the calendar month in Element 24G. The quantity in Element 24G must match the number of dates indicated in Element 24A. Refer to Attachment 4 for a sample claim form.

Providers submitting 837 Health Care Claim: Professional (837P) transactions will indicate individual DOS per detail line. Providers may indicate a range of dates per detail line using the 837P transaction only when the service is performed on consecutive days.

**Information Regarding Medicaid HMOs**

This Update contains Medicaid fee-for-service policy and applies to providers of services to recipients on fee-for-service Medicaid only. For Medicaid HMO or managed care policy, contact the appropriate managed care organization. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.
### ATTACHMENT 1

**Procedure Code Conversion Chart for End-Stage Renal Disease-Related Services**

(Effective for Dates of Service on and After January 1, 2004)

<table>
<thead>
<tr>
<th>Recipients Other Than Home Dialysis (Per Month)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT* Procedure Code</td>
</tr>
<tr>
<td>---------------------</td>
</tr>
<tr>
<td>90918</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>90919</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>90920</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>90921</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Dialysis Recipients (Per Month)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT* Procedure Code</td>
</tr>
<tr>
<td>---------------------</td>
</tr>
<tr>
<td>None</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Dialysis Recipients (Per Day)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT* Procedure Code</td>
</tr>
<tr>
<td>---------------------</td>
</tr>
<tr>
<td>90922</td>
</tr>
<tr>
<td>90923</td>
</tr>
<tr>
<td>90924</td>
</tr>
<tr>
<td>90925</td>
</tr>
</tbody>
</table>

**HCPCS — Healthcare Common Procedure Coding System.
**ATTACHMENT 2**

Sample CMS 1500 Claim Form for End-Stage Renal Disease-Related Services

(Recipient Other Than Home Dialysis)

---

### HEALTH INSURANCE CLAIM FORM

<table>
<thead>
<tr>
<th>1. <strong>Date of Current Hospitalization</strong></th>
<th>15. <strong>If Patient Has Had Same or Similar Illness</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MM</strong></td>
<td><strong>DD</strong></td>
</tr>
<tr>
<td>06</td>
<td>01</td>
</tr>
</tbody>
</table>

### Diagnosis Code

<table>
<thead>
<tr>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J</th>
<th>K</th>
</tr>
</thead>
<tbody>
<tr>
<td>XXX</td>
<td>XX</td>
<td>1.0</td>
<td>12345678</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**I.M. Billing**

1 W. Williams

Anytown, WI 55555

87654321

---

**Sample CMS 1500 Claim Form**

**Recipient, Im A.**

609 Willow St

Anytown, WI

55555

**Telephone (Include Area Code):**

**(xxx) XXX-XXXX**

**City:**

**State:**

**Zip Code:**

**55555**

**Recipient, Im A.**

02/10/96

**Address:**

609 Willow St

Anytown, WI

**Telephone:**

**Employed:**

**Part-Time Student:**

**Married:**

**Other:**

**Sex:**

M

**Sex:**

F

**Insurance Plan Name or Program Name:**

10d. Reserved for Local Use

**Other Accident?**

**Other:**

**Employer’s Name or School Name:**

10c. **Insurance Plan Name or Program Name:**

10d. Reserved for Local Use

**Has Employee Paid Any Part of This Bill Before It Was Submitted to the Insurance Carrier?**

**No**

**Is There Another Health Benefit Plan?**

**No**

---

**Diagnosis Code:**

<table>
<thead>
<tr>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J</th>
<th>K</th>
</tr>
</thead>
<tbody>
<tr>
<td>XXX</td>
<td>XX</td>
<td>1.0</td>
<td>12345678</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Physician or Supplier Information**

**Federal Tax I.D. Number:**

**Social Security Number (SSN):**

**Employer ID Number (EIN):**

**Bill to:**

I.M. Billing

1 W. Williams

Anytown, WI

55555

87654321

---

**Attachment 2:**

Sample CMS 1500 Claim Form for End-Stage Renal Disease-Related Services (Recipient Other Than Home Dialysis)
## ATTACHMENT 3

### Sample CMS 1500 Claim Form for End-Stage Renal Disease-Related Services (Home Dialysis Recipient)

**Health Insurance Claim Form**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Claim Number</strong></td>
<td>1234567890</td>
</tr>
<tr>
<td><strong>Recipient</strong></td>
<td>Im A.</td>
</tr>
<tr>
<td><strong>Address</strong></td>
<td>609 Willow St, Anytown, WI</td>
</tr>
<tr>
<td><strong>Date</strong></td>
<td>09/01/04</td>
</tr>
<tr>
<td><strong>Diagnosis Code</strong></td>
<td>XXX</td>
</tr>
</tbody>
</table>

**Diagnosis Details**

- **ICD-9 Code**: G0322
- **Place of Service**: 12

**Claim Information**

- **Medicare Number**: 1234JED
- **Provider**: I.M. Billing
- **Address**: 1 W. Williams, Anytown, WI 55555

**Financial Information**

- **Total Charge**: $XXX
- **Amount Paid**: $XX
- **Balance Due**: $XX

**Signatures**

- **Provider Signature**: J.M. Outhier

---

**Notes**

- This form is used for claims related to end-stage renal disease, specifically for home dialysis recipients.
- The form includes detailed sections for the recipient's information, diagnosis, and financial details.
- It is designed to ensure accurate billing and payment for medical services related to end-stage renal disease.
### Sample CMS 1500 Claim Form for End-Stage Renal Disease-Related Services (Home Dialysis Recipient) **Wisconsin Medicaid and BadgerCare Service-Specific Information**

**ATTACHMENT 4**

1. **HEALTH INSURANCE CLAIM FORM**
   - **PICA**
   - **HEALTH PLAN**
   - **FEDERAL (BK) LUNG**
   - **GROUP**
   - **MEDICARE**
   - **MEDICAID**
   - **CHAMPUS**
   - **CHAMPA**
   - **INSURED’S ID NUMBER (FOR PROGRAM IN ITEM 1)**
   - **1234567890**

2. **PATIENT’S NAME (Last Name, First Name, Middle Initial)**
   - **Recipient, Im A.**
   - **SEX**
   - **N**

3. **PATIENT’S DATE OF BIRTH**
   - **02-10-96**

4. **PATIENT’S ADDRESS (No., Street)**
   - **609 Willow St**

5. **CITY**
   - **Anytown**

6. **STATE**
   - **WA**

7. **ZIP CODE**
   - **55555**

8. **OTHER INSURED’S NAME (Last Name, First Name, Middle Initial)**
   - **P 1234567890**

9. **Recipient, Im A.**

10. **DATE OF BIRTH**
    - **MM/DD/YY**

11. **ILLNESS (First symptoms or illness) or injury (accident or pregnancy)**
    - **MM/DD/YY**

12. **NAME OF REFERRING PHYSICIAN OR OTHER SOURCE**
    - **G0325**

13. **I.D. NUMBER OF REFERRING PHYSICIAN**
    - **1234567890**

14. **DATE OF CURRENT ILLNESS**
    - **MM/DD/YY**

15. **DIAGNOSIS CODE**
    - **XXX XX 4.0**

16. **CHARGE**
    - **1234567890**

17. **DATE**
    - **08-01-04 08-04-12**

18. **PROCEDURE**
    - **G0325**

19. **MODIFIER**
    - **1**

20. **BILLING INFORMATION**
    - **I.M. Billings**
    - **1 W. Williams**
    - **Anytown, WI 55555**
    - **87654321**

21. **SIGNATURE**
    - **MM/DD/YY**

22. **RECEIVED DATE AND TIME**
    - **MM/DD/YY**

23. **ATTACHMENT 4**

**Wisconsin Medicaid and BadgerCare Service-Specific Information**

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