

To:
Hospital-Affiliated
End-Stage Renal
Disease
Providers
HMOs and Other
Managed Care
Programs

Revised Hospital-Affiliated End-Stage Renal Disease Provider Reimbursement

Effective for dates of service on and after November 1, 2005, as required by 2005 Wisconsin Act 25, the 2005-07 biennial budget, Wisconsin Medicaid will adopt Medicare's reimbursement methodology for end-stage renal disease (ESRD) services claims submitted by hospital-affiliated ESRD providers.

New Reimbursement Methodology

The 2005 Wisconsin Act 25, the 2005-07 biennial budget, requires Wisconsin Medicaid to adopt Medicare's reimbursement methodology for end-stage renal disease (ESRD) services claims submitted by hospital-affiliated ESRD providers. (A Medicaid-certified hospital-affiliated ESRD provider operates under the common ownership, licensure, or control of a hospital, but is not an outpatient hospital.) Medicare's reimbursement methodology applies to claims submitted to Wisconsin Medicaid directly *and* to crossover claims.

Refer to the Attachment of this *Wisconsin Medicaid and BadgerCare Update* for the revised terms of reimbursement (TOR) for hospital-affiliated ESRD providers. The attached TOR replaces previous versions. The revisions will automatically take effect; providers do not need to resubmit certification packets.

Reimbursement for Medicaid-Only Claims

Effective for dates of service (DOS) on and after November 1, 2005, Wisconsin Medicaid will adopt Medicare's reimbursement methodology for Medicaid-only claims submitted by hospital-affiliated ESRD providers.

Wisconsin Medicaid will reimburse hospital-affiliated ESRD providers the *full* Medicare-allowed amount minus any applicable Medicaid copayments. The Medicaid copayment for ESRD services is \$3.00 per DOS only when dialysis is *not* provided on the DOS. Wisconsin Medicaid will *not* subtract Medicare's coinsurance, deductible, or Renal Network fee from the reimbursement.

For recipients receiving *home dialysis* services, hospital-affiliated ESRD providers are required to provide all equipment, supplies, and support services (Medicare Method I) and submit claims appropriately. Wisconsin Medicaid will reimburse the provider according to their Medicare Method I composite rate.

Reimbursement for Crossover Claims

Wisconsin Medicaid will continue to reimburse hospital-affiliated ESRD providers the *full* coinsurance, deductible, and Medicare copayment amounts minus any applicable

Medicaid copayments. The Medicaid copayment for ESRD services is \$3.00 per DOS.

There are no additional requirements needed when billing for crossover claims.

Medicaid Adopting Medicare's Claim Submission Completion Instructions

To implement Medicare's reimbursement methodology, Wisconsin Medicaid will require hospital-affiliated ESRD providers to follow Medicare's claim submission instructions for all claims (whether Medicaid-only or crossover claims) with DOS on and after November 1, 2005. Refer to the Centers for Medicare and Medicaid Services Web site at www.cms.hhs.gov/ or the United Government Services, LLC, Web site at www.ugsmedicare.com/ for the instructions.

Note: Providers are reminded that they should still include relevant Medicaid information (e.g., the Medicaid eight-digit provider number or the recipient's 10-digit Medicaid identification number) when submitting claims.

In addition to Medicare's billing instructions, providers are required to indicate the individual DOS on the claim details, up to four DOS per detail line. If individual DOS are not included on a claim, providers will be required to indicate the individual DOS by either adjusting the claim if it was partially paid or resubmitting the claim if it was denied. A provider's claim may be denied or a provider may not receive full Medicaid reimbursement if individual DOS are not indicated.

Electronic Claims

Providers submitting electronic claims using the 837 Health Care Claim: Institutional (837I) transaction are required to indicate individual DOS on the claim detail. Wisconsin Medicaid

will allow a range of dates on a claim detail only when an *identical* service is performed on *consecutive* days. For example, a provider may submit a claim with revenue code 0821 for a date range of July 1, 2005, through July 14, 2005, only if hemodialysis is provided on all of those 14 days.

Questions pertaining specifically to the 837I transaction may be directed to the Division of Health Care Financing Electronic Data Interchange Helpdesk via telephone at (608) 221-9036 or via e-mail at wiedi@dhfs.state.wi.us.

Paper Claims

Providers submitting paper claims may indicate up to four individual DOS per detail when an identical service is performed on those days.

Future Changes

Wisconsin Medicaid will automatically adopt all future changes made by Medicare regarding billing instructions for hospital-affiliated ESRD providers. If Medicare makes a change to the billing instructions, hospital-affiliated ESRD providers will be required to follow Medicare's billing instructions for all claims (whether Medicaid-only or crossover claims) submitted to Wisconsin Medicaid.

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.

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at dhfs.wisconsin.gov/medicaid/.

PHC 1250

ATTACHMENT
Hospital-Affiliated End-Stage Renal Disease Provider
Terms of Reimbursement

(A copy of the "Hospital-Affiliated End Stage Renal Disease Provider Terms of Reimbursement" is located on the following page.)



DIVISION OF HEALTH CARE FINANCING
 WISCONSIN MEDICAID AND BADGERCARE
 PROVIDER SERVICES
 6406 BRIDGE ROAD
 MADISON WI 53784

Jim Doyle
 Governor

Helene Nelson
 Secretary

State of Wisconsin
 Department of Health and Family Services

Telephone: 800-947-9627
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**HOSPITAL-AFFILIATED END STAGE RENAL DISEASE PROVIDER
 TERMS OF REIMBURSEMENT**

The Department will adopt Medicare’s pricing methodology for hospital-affiliated end stage renal disease (ESRD) services. Hospital-affiliated ESRD rates may be adjusted to reflect changes in Center for Medicare and Medicaid Services (CMS) Medicare regulations, Medicare policy, Medicaid budgetary constraints, and other relevant economic limitations.

For dates of service on and after November 1, 2005, Medicaid providers will be reimbursed for dialysis and dialysis-related services in accordance with Medicare’s ESRD policies and pricing methodologies. Wisconsin Medicaid will not subtract Medicare’s coinsurance, deductible, or Renal Network fee from the reimbursement. Wisconsin Medicaid will reimburse providers according to their Medicare Method I composite rate for home dialysis recipients.

Providers are required to bill their usual and customary charges for services provided. The usual and customary charge is the amount charged by the provider for the same service when provided to non-Medicaid patients. For providers using a sliding fee scale for specific services, the usual and customary charge is the median of the individual provider’s charge for the service when provided to non-Medicaid patients.

For each covered service, the Department shall pay the hospital-affiliated rates established by CMS. Medicaid reimbursement, less appropriate copayments and payments by other insurers, will be considered payment in full.

The Department will reduce payments made to providers to reflect the amounts of any allowable copayments which providers are required to collect pursuant to Chapter 49, Wisconsin Statutes.

Payments for deductible and coinsurance payable on an assigned Medicare claim and shall be made in accordance with Section 49.46(2)(c), Wisconsin Statutes.

In accordance with Federal regulations contained in 42 CFR 447.205, the Department will provide public notice in advance of the effective date of any significant proposed change in its methods and standards for setting rates for services.

Applicable Provider Type(s): 73, Specialty 051

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Effective Date: April 1, 1991
 Renewed: April 1, 1994
 Revised: October 2005