



Update

August 2011

No. 2011-45

Affected Programs: BadgerCare Plus, Medicaid, Wisconsin Chronic Disease Program
To: End-Stage Renal Disease Service Providers, HMOs and Other Managed Care Programs

Changes to Claim Submission and Reimbursement Policy for End-Stage Renal Disease Services

Effective for claims received on and after September 10, 2011, ForwardHealth is changing its claims submission and reimbursement policy for end-stage renal disease (ESRD) services provided by a free-standing or hospital-affiliated ESRD provider.

Changes to Claim Form Completion Instructions and Reimbursement Policy for End-Stage Renal Disease Services

Effective for claims received on and after September 10, 2011, regardless of dates of service (DOS), free-standing and hospital-affiliated end-stage renal disease (ESRD) providers will be required to submit claims for ESRD services using ForwardHealth's claim form completion instructions in Attachment 1 of this *ForwardHealth Update* instead of Medicare's claim submission instructions, as currently required.

Also effective for claims received on and after September 10, 2011, claims for ESRD services from free-standing and hospital-affiliated ESRD providers will be reimbursed at a rate not to exceed 80 percent of Medicare's per diem rates. This includes any ESRD claims that have been previously submitted to ForwardHealth but have not adjudicated by September 10, 2011.

Adjustment requests received on and after September 10, 2011, for claims adjudicated and placed into a "Pay" status before September 10, 2011, must conform to the new ESRD

claim completion instructions. So the provider's adjustment request must include changes to the original claim that will enable it to process in conformity with the new billing requirements. Also, when the adjustment claim successfully processes, it will be priced according to ForwardHealth's new reimbursement policy for ESRD claims.

Lastly, providers will also be allowed to resubmit claims for ESRD services that may have been incorrectly denied for claims processed from November 10, 2008, to September 9, 2011.

Changes to the reimbursement policy and claim form completion instructions apply to ESRD providers rendering services to all members for whom ESRD services are covered services (i.e., members enrolled in Wisconsin Medicaid, the BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan, the BadgerCare Plus Basic Plan, and the Wisconsin Chronic Disease Program [WCDP]). Refer to the Online Handbook on the ForwardHealth Portal at www.forwardhealth.wi.gov/ for plan-specific service limitations.

The changes described in this *Update* are being made in response to provider issues with claims processing for ESRD services.

Claims Submission

Paper Claims Submission

Paper claims from ESRD providers must be submitted using the UB-04 (CMS 1450) Claim Form. Claims submitted on any other claim form will be denied. ForwardHealth does not provide the UB-04 Claim Form, which may be obtained from any federal forms supplier.

Claim Form Completion Instructions

ForwardHealth has created claim form completion instructions for the UB-04 Claim Form to be used by ESRD providers. Providers will be required to submit claims for ESRD services using the ESRD services completion instructions for claims received by ForwardHealth on and after September 10, 2011, regardless of the DOS billed on the claim. See Attachment 1 for the UB-04 (CMS 1450) Claim Form completion instructions for ESRD providers.

Electronic Claims Submission

Providers are encouraged to submit claims electronically since electronic claims submissions usually reduce claim errors and expedite reimbursement. Electronic claims for ESRD services must be submitted on an institutional claim using one of the following methods:

- 837 Health Care Claim: Institutional transaction.
- Direct Data Entry on the ForwardHealth Portal.
- Provider Electronic Solutions (PES) software, which may be downloaded from the Portal. Providers may call the Electronic Data Interchange Helpdesk at (866) 416-4979 for assistance with downloading the PES software.

Providers should refer to the UB-04 (CMS 1450) Claim Form Completion Instructions for ESRD Providers in Attachment 1 when completing electronic claims submissions for ESRD services. Refer to the Claims section of the Online Handbook for more information about electronic and paper claims submission.

End-Stage Renal Disease Claims for HMO Members

There is no change to claims submission policy for members enrolled in state-contracted managed care organizations (MCOs). For members enrolled in state-contracted MCOs, except those enrolled in the Program for All Inclusive Care for the Elderly (PACE) and Family Care Partnership, providers submit claims for ESRD services to the member's MCO. For provider-administered drugs and corresponding administration fees listed in Attachment 2, providers should continue to submit their claims to ForwardHealth fee-for-service on an institutional claim.

Providers will be reimbursed at the maximum allowable fee rate by fee-for-service for the provider-administered drugs and corresponding administration fees listed in Attachment 2.

Claims and adjustments to claims for HMO members submitted for fee-for-service reimbursement should include only the details that can be reimbursed fee-for-service. If a provider submits to fee-for-service a claim with details reimbursable by the member's MCO, the HMO-covered services will be denied, but the fee-for-service details will be reimbursed.

All fee-for-service policies and procedures, including copayment, cost sharing, diagnosis restriction, prior authorization, and pricing policies, apply to claims submitted to fee-for-service for provider-administered drugs and corresponding administration fees. Refer to the Online Handbook for complete policy regarding coverage for drugs.

Refer to the Online Handbook for additional policy information regarding claim submission and reimbursement for provider-administered drugs and corresponding administration fees.

Previously Denied Claims

Providers may resubmit claims for ESRD services that may have been incorrectly denied from November 10, 2008, to September 9, 2011. Denied claims having any DOS within

the 365-day timely filing limit for Wisconsin Medicaid, or the 730-day timely filing limit for WCDP, must be resubmitted through the normal claims processing channels. Previously denied claims having DOS that exceed the timely filing limit must be submitted through the Timely Filing Appeals process. Timely Filing Appeals Requests for previously denied ESRD claims must be received by ForwardHealth Timely Filing on or before December 9, 2011.

Submitting Timely Filing Appeals Requests for Denied Claims

When submitting Timely Filing Appeals Requests for denied claims, providers are required to submit the following:

- A legible claim, completed according to the claim form completion instructions found in Attachment 1.
- A properly completed Timely Filing Appeals Request, F-13047 (10/08), for each group of affected claims.

Providers may submit a single Timely Filing Appeals Request form per batch of claims that are beyond the timely filing deadline. When completing the Timely Filing Appeals Request, providers should check the “ForwardHealth Reconsideration” box and write in the blank space provided immediately above the signature/date line, “ESRD resubmission — Update 2011-45.”

Providers should refer to the Claims section and Timely Filing Appeals chapter of their Online Handbook for more information about timely filing appeals.

Refunding Payments to Members

For claims that were previously denied and now are paid, the provider may have received payment from the member for the service(s). For members enrolled in the Standard Plan, the Benchmark Plan, Wisconsin Medicaid, and WCDP, the provider is required to return to the member an amount equal to ForwardHealth’s reimbursement. For members enrolled in the Core Plan or the Basic Plan, providers are required to return the full payment amount received from the member.

Reimbursement

End-stage renal disease claims will be reimbursed using either a per diem rate or a maximum allowable fee, depending on the service billed. Effective for claims processed on and after September 10, 2011, regardless of DOS:

- End-stage renal disease services will be reimbursed at a per diem rate not to exceed 80 percent of Medicare’s rate. Rates could change at any time. The current per diem rate is **\$214.60** which is applicable on ESRD claims for any DOS. ForwardHealth reimburses DOS for which a revenue code in a range from 082X to 088X is billed. Any institutional claim without a revenue code within this range will be denied. The Medicaid per diem rate will include reimbursement for all drugs and administration fees related to the ESRD service for which the claim is submitted.

Providers can find their ESRD per diem rates on the Portal by following these steps:

1. Select the *Providers* button on the ForwardHealth home page.
 2. Select *Provider-specific Resources*.
 3. Go to End Stage Renal Disease in the Provider Type column.
 4. Select *More Information* in the Resources column.
- Laboratory services will be reimbursed at the lesser of their billed amount and the maximum allowable fee for the procedure when billed on a professional claim.

Revised Terms of Reimbursement

The Free-Standing End-Stage Renal Disease Provider Terms of Reimbursement (TOR), F-01094 (08/11), and the Hospital-Affiliated End-Stage Renal Disease Provider Terms of Reimbursement, F-01095 (08/11), have been revised. Refer to Attachments 3 and 4 for the revised TORs for ESRD providers. The TOR describes how providers will be reimbursed for services rendered. The attached TORs replace the previous versions.

Changes to End-Stage Renal Disease Crossover Claim Reimbursement

Effective for all ESRD crossover claims and adjustments processed on and after September 10, 2011, detail-level information will be used to calculate pricing for Medicare coinsurance. Details that Medicare paid in full, or that Medicare denied, will not be considered for reimbursement. Providers will be reimbursed the lesser of the Medicaid allowed amount minus the Medicare paid amount, or the sum of the Medicare coinsurance and copayment.

Medicare deductibles are paid in full by ForwardHealth.

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

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at www.forwardhealth.wi.gov/.

P-1250

ATTACHMENT 1

UB-04 (CMS 1450) Claim Form Completion Instructions for End-Stage Renal Disease Providers

Effective for claims received on and after September 10, 2011.

A sample UB-04 claim form is available for end-stage renal disease (ESRD) services.

Use the following claim form completion instructions, *not* the form locator descriptions printed on the claim form, to avoid claim denial or inaccurate claim payment. Complete all form locators unless otherwise indicated. Do not include attachments unless instructed to do so.

These instructions are for the completion of the UB-04 claim for ForwardHealth. For complete billing instructions, refer to the National UB-04 Uniform Billing Manual prepared by the National Uniform Billing Committee (NUBC). The National UB-04 Uniform Billing Manual contains important coding information not available in these instructions. Providers may purchase the National UB-04 Uniform Billing Manual by calling (312) 422-3390 or by accessing the NUBC Web site at www.nubc.org/.

Members enrolled in BadgerCare Plus, Medicaid, or Wisconsin Chronic Disease Program (WCDP) receive a ForwardHealth identification card. Always verify a member's enrollment before providing nonemergency services to determine if there are any limitations on covered services and to obtain the correct spelling of the member's name. Refer to the Online Handbook in the Provider area of the ForwardHealth Portal at www.forwardhealth.wi.gov/ for more information about verifying enrollment.

Note: Each provider is solely responsible for the truthfulness, accuracy, timeliness, and completeness of claims relating to reimbursement for services submitted to ForwardHealth.

Submit completed paper claims to the following address:

ForwardHealth
Claims and Adjustments
6406 Bridge Rd
Madison WI 53784-0002

WCDP
PO Box 6410
Madison WI 53716-0410

Form Locator 1 — Provider Name, Address, and Telephone Number

Enter the name of the ESRD provider submitting the claim and the provider's complete mailing address. The minimum requirement is the name, city, state, and ZIP+4 code. The name in Form Locator 1 should correspond with the National Provider Identifier (NPI) in Form Locator 56.

Form Locator 2 — Pay-to Name, Address, and ID (not required)

Form Locator 3a — Pat. Cntl # (optional)

Providers may enter up to 20 characters of the patient's internal office account number. This number will appear on the Remittance Advice (RA) and/or the 835 Health Care Claim Payment/Advice (835) transaction.

Form Locator 3b — Med. Rec. # (optional)

Enter the number assigned to the patient's medical/health record by the provider. This number will appear on the RA and/or the 835 transaction.

Form Locator 4 — Type of Bill

Exclude the leading zero and enter the three-digit type of bill code 721.

Form Locator 5 — Fed. Tax No.

Data are required in this element for Optical Character Recognition (OCR) processing. Any information populated by a provider's computer software is acceptable data for this element. If computer software does not automatically complete this element, enter information such as the provider's federal tax identification number.

Form Locator 6 — Statement Covers Period (From - Through)

Enter both dates in MM/DD/YY format (e.g., November 3, 2008, would be 11/03/08).

Form Locator 7 — Unlabeled Field (not required)

Form Locator 8 a-b — Patient Name

Enter the member's last name and first name, separated by a space or comma, in Form Locator 8b. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth card and the EVS do not match, use the spelling from the EVS.

Form Locator 9 a-e — Patient Address

Data are required in this element for OCR processing. Any information populated by a provider's computer software is acceptable data for this element (e.g., "On file"). If computer software does not automatically complete this element, enter information such as the member's complete address in Form Locator 9a.

Form Locator 10 — Birthdate

Enter the member's birth date in MMDDCCYY format (e.g., September 25, 1975, would be 09251975).

Form Locator 11 — Sex (not required)

Form Locator 12 — Admission Date (not required)

Form Locator 13 — Admission Hr (not required)
Form Locator 14 — Admission Type (not required)

Form Locator 15 — Admission Src

Form Locator 16 — DHR (not required)

Form Locator 17 — Stat (not required)

Form Locators 18-28 — Condition Codes (required, if applicable)

Enter the code(s) identifying a condition related to this claim, if appropriate. Refer to the National UB-04 Uniform Billing Manual for more information.

Form Locator 29 — ACDT State (not required)

Form Locator 30 — Unlabeled Field (not required)

Form Locators 31-34 — Occurrence Code and Date (required, if applicable)

If appropriate, enter the code and associated date defining a significant event relating to this claim that may affect payer processing. All dates must be printed in the MMDDYY format. Refer to the National UB-04 Uniform Billing Manual for more information.

Form Locators 35-36 — Occurrence Span Code (From - Through) (not required)

Form Locator 37 — Unlabeled Field (not required)

Form Locator 38 — Responsible Party Name and Address (not required)

Form Locators 39-41 a-d — Value Code and Amount (not required)

Form Locator 42 — Rev. Cd.

Enter the appropriate four-digit revenue code as defined by the NUBC that identifies a specific accommodation or ancillary service. Refer to the ESRD Online Handbook or the National UB-04 Uniform Billing Manual for information and codes.

Form Locator 43 — Description (not required)

Form Locator 44 — HCPCS/Rate/HIPPS Code (required, if applicable)

Enter the appropriate corresponding Healthcare Common Procedure Coding System (HCPCS) or *Current Procedural Terminology* (CPT) code that corresponds to the revenue codes listed in Form Locator 42. Certain revenue codes do not require HCPCS or CPT procedure codes.

Form Locator 45 — Serv. Date

Enter the single “from” date of service (DOS) in MMDDYY format in this form locator.

Form Locator 46 — Serv. Units

Enter the number of covered accommodation days or ancillary units of service for each line item.

Form Locator 47 — Total Charges (by Accommodation/Ancillary Code Category)

Enter the usual and customary charges pertaining to the related revenue code for the current billing period as entered in Form Locator 6.

Form Locator 48 — Non-covered Charges (not required)**Form Locator 49 — Unlabeled Field**

Enter the “to” DOS in DD format if billing a span of consecutive DOS.

Detail Line 23

PAGE ___ OF ___

Enter the current page number in the first blank and the total number of pages in the second blank. This information must be included for both single- and multiple-page claims.

CREATION DATE (not required)

TOTALS

Enter the sum of all charges for the claim in this field. If submitting a multiple-page claim, enter the total charge for the claim (i.e., the sum of all details from all pages of the claim) *only on the last page of the claim*.

Form Locator 50 A-C — Payer Name

Enter all health insurance payers here. Enter “T19” for Wisconsin Medicaid and the name of the commercial health insurance, if applicable. If submitting a multiple-page claim, enter health insurance payers only on the *first page* of the claim.

Form Locator 51 A-C — Health Plan ID (not required)**Form Locator 52 A-C — Rel. Info (not required)****Form Locator 53 A-C — Asg. Ben. (not required)****Form Locator 54 A-C — Prior Payments (required, if applicable)**

Enter the actual amount paid by commercial health insurance. (If the dollar amount indicated in Form Locator 54 is greater than zero, “OI-P” must be indicated in Form Locator 80.) If the commercial health insurance denied the claim, enter “000.” Do **not** enter Medicare-paid amounts in this field.

If submitting a multiple-page claim, enter the amount paid by commercial health insurance only on the *first page* of the claim.

Form Locator 55 A-C — Est. Amount Due (not required)**Form Locator 56 — NPI**

Enter the provider's NPI. The NPI in Form Locator 56 should correspond with the name in Form Locator 1.

Form Locator 57 — Other Provider ID (not required)

Form Locator 58 A-C — Insured’s Name

Data are required in this element for OCR processing. Any information populated by a provider’s computer software is acceptable data for this element (e.g., “Same”). If computer software does not automatically complete this element, enter information such as the member’s last name, first name, and middle initial.

Form Locator 59 A-C — P. Rel (not required)**Form Locator 60 A-C — Insured’s Unique ID**

Enter the member identification number. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

Form Locator 61 A-C — Group Name (not required)**Form Locator 62 A-C — Insurance Group No. (not required)****Form Locator 63 A-C — Treatment Authorization Codes (not required)****Form Locator 64 A-C — Document Control Number (not required)****Form Locator 65 A-C — Employer Name (not required)****Form Locator 66 — Dx (not required)****Form Locator 67 — Prin. Diag. Cd.**

Enter the valid, most specific *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) code (up to five digits) describing the principal diagnosis (e.g., the condition established after study to be chiefly responsible for causing the admission or other health care episode). The principal diagnosis identifies the condition chiefly responsible for the patient’s visit or treatment. Do not enter manifestation codes as the principal diagnosis; code the underlying disease first. The principal diagnosis may not include “E” (etiology) codes. “V” codes may be used as the principal diagnosis.

Form Locators 67A-Q — Other Diag. Codes

Enter valid, most specific ICD-9-CM diagnosis codes (up to five digits) corresponding to additional conditions that coexist at the time of admission, or develop subsequently, and that have an effect on the treatment received or the length of stay. Diagnoses that relate to an earlier episode and have no bearing on this episode are to be excluded. Providers should prioritize diagnosis codes as relevant to this claim.

Form Locator 68 — Unlabeled Field (not required)**Form Locator 69 — Admit Dx (not required)****Form Locator 70 — Patient Reason Dx (not required)****Form Locator 71 — PPS Code (not required)**

Form Locator 72 — ECI (not required)

Form Locator 73 — Unlabeled Field (not required)

Form Locator 74 — Principal Procedure Code and Date (not required)

Form Locator 74a-e — Other Procedure Code and Date (not required)

Form Locator 75 — Unlabeled Field (not required)

Form Locator 76 — Attending

Enter the attending provider's NPI.

Form Locator 77 — Operating (not required)

Form Locators 78 and 79 — Other (not required)

Form Locator 80 — Remarks (enter information when applicable)

Commercial Health Insurance Billing Information

Commercial health insurance coverage must be billed prior to billing ForwardHealth, unless the service does not require commercial health insurance billing as determined by ForwardHealth.

When the member has dental ("DEN"), Medicare Cost ("MCC"), Medicare + Choice ("MPC") insurance only, or has no commercial health insurance, do not indicate an other insurance (OI) explanation code in Form Locator 80.

Code	Description
OI-P	PAID in part or in full by commercial health insurance or commercial HMO. In Form Locator 54 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do not use this code unless the claim was actually billed to the commercial health insurer.
OI-Y	YES, the member has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to, the following: <ul style="list-style-type: none">• The member denied coverage or will not cooperate.• The provider knows the service in question is not covered by the carrier.• The member's commercial health insurance failed to respond to initial and follow-up claims.• Benefits are not assignable or cannot get assignment.• Benefits are exhausted.

Note: The provider may not use OI-D or OI-Y if the member is covered by a commercial HMO and the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by a commercial HMO are not reimbursable by ForwardHealth except for the copayment and deductible amounts. Providers who receive a

capitation payment from the commercial HMO may not submit claims to ForwardHealth for services that are included in the capitation payment.

Medicare Information

Use Form Locator 80 for Medicare information. Submit claims to Medicare before billing ForwardHealth.

Do not indicate a Medicare disclaimer code when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- ForwardHealth indicates the member does not have any Medicare coverage for the service provided. For example, the service is covered by Medicare Part A, but the member does not have Medicare Part A.
- ForwardHealth indicates the provider is not Medicare certified.

Note: Home health agencies, medical equipment vendors, pharmacies, and physician services providers must be Medicare certified to perform Medicare-covered services for dual eligibles.

- Medicare has allowed the charges. In this case, attach Medicare remittance information, but do not indicate on the claim form the amount Medicare paid.

If none of the above is true, a Medicare disclaimer code is necessary. The following Medicare disclaimer codes may be used when appropriate.

Code	Description
M-7	<p>Medicare disallowed or denied payment. This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the member's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. Use M-7 in the following instances.</p> <p><i>For Medicare Part A, use M-7 in the following instances (all three criteria must be met):</i></p> <ul style="list-style-type: none"> • The provider is identified in ForwardHealth files as certified for Medicare Part A. • The member is eligible for Medicare Part A. • The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted. <p><i>For Medicare Part B, use M-7 in the following instances (all three criteria must be met):</i></p> <ul style="list-style-type: none"> • The provider is identified in ForwardHealth files as certified for Medicare Part B. • The member is eligible for Medicare Part B. • The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted.
M-8	<p>Noncovered Medicare service. This code may be used when Medicare was not billed because the service is not covered in this circumstance. Use M-8 in the following instances.</p> <p><i>For Medicare Part A, use M-8 in the following instances (all three criteria must be met):</i></p> <ul style="list-style-type: none"> • The provider is identified in ForwardHealth files as certified for Medicare Part A. • The member is eligible for Medicare Part A. • The service is usually covered by Medicare Part A but not in this circumstance (e.g., member's diagnosis). <p><i>For Medicare Part B, use M-8 in the following instances (all three criteria must be met):</i></p> <ul style="list-style-type: none"> • The provider is identified in ForwardHealth files as certified for Medicare Part B. • The member is eligible for Medicare Part B. • The service is usually covered by Medicare Part B but not in this circumstance (e.g., member's diagnosis).

Form Locator 81 a-d — CC

If the billing provider's NPI was indicated in Form Locator 56, enter the qualifier "B3" in the first field to the right of the form locator, followed by the 10-digit provider taxonomy code in the second field.

ATTACHMENT 2

End-Stage Renal Disease Procedure Codes for Fee-for-Service Reimbursement

The end-stage renal disease procedure codes below are reimbursed by fee-for-service for members enrolled in most managed care organizations (MCOs) except those enrolled in the Program for All Inclusive Care for the Elderly (PACE) and Family Care Partnership. Medicare crossover claims for procedure codes and claims for procedure codes not indicated on the table below should be submitted to the member's MCO for reimbursement.

End-Stage Renal Disease Procedure Codes Reimbursed by Fee-for-Service	
Code	Description
90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
90658	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use
90669	Pneumococcal conjugate vaccine, 7 valent, for intramuscular use
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use
90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use
90746	Hepatitis B vaccine, adult dosage, for intramuscular use
90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
96373	intra-arterial
96374	intravenous push, single or initial substance/drug
96375	each additional sequential intravenous push of a new substance/drug
96376	each additional sequential intravenous push of the same substance/drug provided in a facility
96379	Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion
J0610	Injection, calcium gluconate, per 10 ml
J0636	Injection, calcitriol, 0.1 mcg
J0690	Injection, cefazolin sodium, 500 mg
J0692	Injection, cefepime HCL, 500 mg
J0696	Injection, ceftriaxone sodium, per 250 mg
J0713	Injection, ceftazidime, per 500 mg
J0735	Injection, clonidine hydrochloride (HCL), 1 mg
J0878	Injection, daptomycin, 1 mg
J0882	Injection, darbepoetin alfa, 1 microgram (for ESRD on dialysis)

End-Stage Renal Disease Procedure Codes Reimbursed by Fee-for-Service	
Code	Description
J0886	Injection, epoetin alfa, 1000 units (for ESRD on dialysis)
J0895	Injection, deferoxamine mesylate, 500 mg
J1270	Injection, doxercalciferol, 1 mcg
J1440	Injection filgrastim (G-CSF), 300 mcg
J1580	Injection, Garamycin, gentamicin, up to 80 mg
J1590	Injection, gatifloxacin, 10 mg
J1756	Injection, iron sucrose, 1 mg
J1955	Injection, levocarnitine, per 1 gm
J2250	Injection, midazolam hydrochloride, per 1 mg
J2405	Injection, ondansetron hydrochloride, per 1 mg
J2501	Injection, paricalcitol, 1 mcg
J2550	Injection, promethazine HCL, up to 50 mg
J2765	Injection, metoclopramide HCL, up to 10 mg
J2916	Injection, sodium ferric gluconate complex in sucrose injection, 12.5 mg
J2997	Injection, alteplase recombinant, 1 mg
J3010	Injection, fentanyl citrate, 0.1 mg
J3260	Injection, tobramycin sulfate, up to 80 mg
J3370	Injection, vancomycin HCL, 500 mg
J3490	Unclassified drugs
Q4081	Injection, epoetin alfa, 100 units (for ESRD on dialysis)

ATTACHMENT 3

Free-Standing End-Stage Renal Disease Provider Terms of Reimbursement

(A copy of the “Free-Standing End-Stage Renal Disease Provider Terms of Reimbursement” is located on the following page.)



FORWARDHEALTH

PROVIDER SERVICES
6406 BRIDGE ROAD
MADISON WI 53784

Scott Walker
Governor

Dennis G. Smith
Secretary

State of Wisconsin

Department of Health Services

Telephone: 800-947-9627
TTY: 711 or 800-947-3529

www.forwardhealth.wi.gov

FREE-STANDING END-STAGE RENAL DISEASE PROVIDER TERMS OF REIMBURSEMENT

The Department of Health Services (DHS) will adopt a reimbursement rate for free-standing end-stage renal disease (ESRD) providers at a percentage of Medicare's ESRD reimbursement rate.

For claims processed on and after September 10, 2011, Medicaid providers will be reimbursed for dialysis and dialysis-related services not to exceed a percentage, initially 80 percent, of Medicare's ESRD rate. The only exception is that laboratory services are separately reimbursable at a maximum allowable fee.

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 DHS shall pay the free-standing rates, less appropriate copayments and payments by other insurers. This will be considered payment in full.

The DHS will reduce payments made to providers to reflect the amounts of any allowable copayments that providers are required to collect pursuant to ch. 49, Wis. Stats.

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

In accordance with federal regulations contained in 42 CFR 447.205, the DHS 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.

F-01094 (08/11)

ATTACHMENT 4

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.)



FORWARDHEALTH

PROVIDER SERVICES
6406 BRIDGE ROAD
MADISON WI 53784

Scott Walker
Governor

Dennis G. Smith
Secretary

State of Wisconsin

Department of Health Services

Telephone: 800-947-9627
TTY: 711 or 800-947-3529

www.forwardhealth.wi.gov

HOSPITAL-AFFILIATED END-STAGE RENAL DISEASE PROVIDER TERMS OF REIMBURSEMENT

The Department of Health Services (DHS) will adopt a reimbursement rate for hospital-affiliated end-stage renal disease (ESRD) providers at a percentage of Medicare's ESRD reimbursement rate.

For claims processed on and after September 10, 2011, Medicaid providers will be reimbursed for dialysis and dialysis-related services not to exceed a percentage, initially 80 percent, of Medicare's ESRD rate. The only exception is that laboratory services are separately reimbursable at a maximum allowable fee.

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 DHS shall pay the hospital-affiliated rates, less appropriate copayments and payments by other insurers. This will be considered payment in full.

The DHS will reduce payments made to providers to reflect the amounts of any allowable copayments that providers are required to collect pursuant to ch. 49, Wis. Stats.

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

In accordance with federal regulations contained in 42 CFR 447.205, the DHS 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.

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