

Affected Programs: BadgerCare Plus, Medicaid, Wisconsin Chronic Disease Program

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

Policy Clarifications and Reminders for End-Stage Renal Disease Service Providers

This *ForwardHealth Update* serves to clarify and reiterate certain end-stage renal disease policies.

Claim Submission and Reimbursement

With the exception of certain laboratory services listed in this *ForwardHealth Update*, claims from end-stage renal disease (ESRD) providers are required to be submitted as an institutional claim using an electronic 837 Health Care Claim: Institutional transaction, Provider Electronic Solutions (PES) software, or Direct Data Entry (DDE) on the ForwardHealth Portal or using the paper UB-04 (CMS 1450) Claim Form. Claims from ESRD providers submitted on any other claim form will be denied.

Claims from ESRD providers submitted directly to ForwardHealth are reimbursed at a per diem rate.

ForwardHealth uses revenue codes to identify ESRD-related services and reimburses per date of service (DOS) for which a valid dialysis-related revenue code in the range from 082X to 088X is billed. All charges billed for a DOS in which a valid revenue code is billed will be rolled into the per diem rate. Any detail line on an ESRD claim with a revenue code outside this range will reflect a pay status but will not be considered when calculating reimbursement.

Laboratory Services

Most laboratory services are included in the per diem rate and are not separately reimbursable. Refer to Attachment 1 of this *Update* for a list of laboratory procedure codes and descriptions that are included in the per diem rate and will

not be separately reimbursed when submitted on a professional claim. These laboratory services are determined by Medicare and can be found on the Centers for Medicare & Medicaid Services Web site at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Downloads/Items-Services-Consolidated-Billing-ESRD-PPS-2013-CR7869.pdf.

All other laboratory services covered for ESRD service providers may be submitted separately on a professional claim and will be reimbursed at the lesser of the billed amount or the maximum allowable fee for the procedure, but no more than Medicare's rate.

Medicare Crossover Claims

Providers will be reimbursed the lesser of the Medicaid-allowed amount minus the Medicare paid amount, or the sum of the Medicare cost-share. Claim details that Medicare paid in full, or that Medicare denied, will not be considered for reimbursement. Providers are encouraged to report to Wisconsin Medicaid and the Wisconsin Chronic Disease Program (WCDP) all taxonomy codes they have registered with Medicare to help ensure that crossover claims process properly. Providers report taxonomy through the Demographic Maintenance area of their secure Portal account.

Enhanced Ambulatory Patient Groups

The Enhanced Ambulatory Patient Groups (EAPG) reimbursement methodology will not apply to claims submitted by ESRD providers for services provided to

members diagnosed with ESRD because the EAPG reimbursement methodology applies to outpatient hospitals, not ESRD providers; however, there is limited coverage for non-renal disease-related emergency services provided in a hospital setting. Refer to the September 2012 *ForwardHealth Update* (2012-51), titled “Provider Enrollment Policy for End-Stage Renal Disease Services,” for more information.

Members in State-Contracted HMOs

Members enrolled in Medicaid or BadgerCare Plus may be enrolled in state-contracted HMOs. Members enrolled only in the WCDP are not enrolled in state-contracted HMOs.

Providers should submit claims to the member’s HMO for ESRD services provided to Medicaid or BadgerCare Plus members enrolled in state-contracted HMOs, except those enrolled in Family Care.

Enrollment Verification

Providers should *always* verify a member's enrollment before providing services, both to determine enrollment for the current date (since a member's enrollment status may change) and to discover any limitations to the member's coverage.

Providers using the Portal for enrollment verification are reminded that information on members enrolled in Medicaid and BadgerCare Plus, including any HMO assignment, is found within secure Medicaid Portal accounts. Information on members enrolled in WCDP is found within secure WCDP Portal accounts. Providers who accept Medicaid and BadgerCare Plus as well as WCDP members are strongly encouraged to obtain secure Portal accounts under both payers.

Provider-Administered Drugs

For provider-administered drugs and corresponding administration fees listed in Attachment 2 that are administered to members enrolled in state-contracted HMOs, providers should submit their claims to ForwardHealth fee-for-service on an institutional claim.

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/.

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ATTACHMENT 1

Laboratory Procedure Codes Included in the End-Stage Renal Disease Per Diem Rate

The laboratory procedure codes listed below are reimbursed as part of the End-Stage Renal Disease per diem rate when submitted on an institutional claim. The procedure codes will be denied if submitted separately on a professional claim.

Laboratory Procedure Codes Included in the Per Diem Rate	
Procedure Code	Description
80047	Basic metabolic panel (Calcium, ionized)
80048	Basic metabolic panel (Calcium, total)
80051	Electrolyte panel
80053	Comprehensive metabolic panel
80061	Lipid panel
80069	Renal function panel
80076	Hepatic function panel
82040	Albumin; serum, plasma or whole blood
82108	Aluminum
82306	Vitamin D; 25 hydroxy, includes fraction(s), if performed
82310	Calcium; total
82330	ionized
82374	Carbon dioxide (bicarbonate)
82379	Carnitine (total and free), quantitative, each specimen
82435	Chloride; blood
82565	Creatinine; blood
82570	other source
82575	clearance
82607	Cyanocobalamin (Vitamin B-12);
82652	Vitamin D; 1, 25 dihydroxy, includes fraction(s), if performed
82668	Erythropoietin
82728	Ferritin
82746	Folic acid; serum
83540	Iron
83550	Iron binding capacity
83735	Magnesium
83970	Parathormone (parathyroid hormone)
84075	Phosphatase, alkaline;
84100	Phosphorous inorganic (phosphate);
84132	Potassium; serum, plasma or whole blood
84134	Prealbumin

Laboratory Procedure Codes Included in the Per Diem Rate	
Procedure Code	Description
84155	Protein, total, except by refractometry; serum, plasma or whole blood
84157	other source (eg, synovial fluid, cerebrospinal fluid)
84295	Sodium; serum, plasma or whole blood
84466	Transferrin
84520	Urea nitrogen; quantitative
84540	Urea nitrogen, urine
84545	Urea nitrogen, clearance
85014	Blood count; hematocrit (Hct)
85018	hemoglobin (Hgb)
85025	complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
85027	complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)
85041	red blood cell (RBC), automated
85044	reticulocyte, manual
85045	reticulocyte, automated
85046	reticulocytes, automated, including 1 or more cellular parameters (eg, reticulocyte hemoglobin content [CHr], immature reticulocyte fraction [IRF], reticulocyte volume [MRV], RNA content), direct measurement
85048	leukocyte (WBC), automated
86704	Hepatitis B core antibody (HBcAb); total
86705	IgM antibody
86706	Hepatitis B surface antibody (HBsAb)
87040	Culture, bacterial; blood, aerobic, with isolation and presumptive identification of isolates (includes anaerobic culture, if appropriate)
87070	any other source except urine, blood or stool, aerobic, with isolation and presumptive identification of isolates
87071	quantitative, aerobic with isolation and presumptive identification of isolates, any source except urine, blood or stool
87073	quantitative, anaerobic with isolation and presumptive identification of isolates, any source except urine, blood or stool
87075	any source, except blood, anaerobic with isolation and presumptive identification of isolates
87076	anaerobic isolate, additional methods required for definitive identification, each isolate
87077	aerobic isolate, additional methods required for definitive identification, each isolate
87081	Culture, presumptive, pathogenic organisms, screening only;
87340	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; hepatitis B surface antigen (HBsAg)
G0306	Complete CBC, automated (Hgb, HCT, RBC, WBC, without platelet count) and automated WBC differential count
G0307	Complete CBC, automated (Hgb, HCT, RBC, WBC, without platelet count)

ATTACHMENT 2

Provider Administered Drugs Reimbursed on a Fee-for-Service Basis

The procedure codes below are reimbursed fee-for-service for members enrolled in most state-contracted HMOs, 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 HMO for reimbursement.

Procedure Codes Reimbursed Fee-for-Service		
Code	Description	Maximum Allowable Fee
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	\$3.31
96373	intra-arterial	\$15.78
96374	intravenous push, single or initial substance/drug	\$46.21
96375	each additional sequential intravenous push of a new substance/drug	\$21.52
96376	each additional sequential intravenous push of the same substance/drug provided in a facility	\$24.16
96379	Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion	Manually priced
J0610	Injection, calcium gluconate, per 10 ml	\$0.64
J0636	Injection, calcitriol, 0.1 mcg	\$0.40
J0690	Injection, cefezolin sodium, 500 mg	\$0.74
J0692	Injection, cefepime HCL, 500 mg	\$2.32
J0696	Injection, ceftriaxone sodium, per 250 mg	\$0.72
J0713	Injection, ceftazidime, per 500 mg	\$2.62
J0735	Injection, clonidine hydrochloride (HCL), 1 mg	\$22.87
J0878	Injection, daptomycin, 1 mg	\$0.54
J0882	Injection, darbepoetin alfa, 1 microgram (for ESRD on dialysis)	\$3.32
J0886	Injection, epoetin alfa, 1000 units (for ESRD on dialysis)	\$9.87
J0895	Injection, deferoxamine mesylate, 500 mg	\$8.50
J1270	Injection, doxercalciferol, 1 mcg	\$0.94
J1440	Injection filgrastim (G-CSF), 300 mcg	\$268.91
J1580	Injection, Garamycin, gentamicin, up to 80 mg	\$1.29
J1590	Injection, gatifloxacin, 10 mg	\$0.80
J1756	Injection, iron sucrose, 1 mg	\$0.29
J1955	Injection, levocarnitine, per 1 gm	\$6.24
J2250	Injection, midazolam hydrochloride, per 1 mg	\$0.16

Procedure Codes Reimbursed Fee-for-Service		
Code	Description	Maximum Allowable Fee
J2405	Injection, ondansetron hydrochloride, per 1 mg	\$0.22
J2501	Injection, paricalcitol, 1 mcg	\$1.74
J2550	Injection, promethazine HCL, up to 50 mg	\$1.90
J2765	Injection, metoclopramide HCL, up to 10 mg	\$0.36
J2916	Injection, sodium ferric gluconate complex in sucrose injection, 12.5 mg	\$3.32
J2997	Injection, alteplase recombinant, 1 mg	\$49.22
J3010	Injection, fentanyl citrate, 0.1 mg	\$0.80
J3260	Injection, tobramycin sulfate, up to 80 mg	\$2.75
J3370	Injection, vancomycin HCL, 500 mg	\$2.40
J3490	Unclassified drugs	Manually priced
Q4081	Injection, epoetin alfa, 100 units (for ESRD on dialysis)	\$0.99