



# *End Stage Renal Disease Facilities*

---

## TABLE OF CONTENTS

- I. [General Guidelines](#)
- II. [Composite Rate](#)
  - a. Routine items and services
  - b. Laboratory
  - c. Drug
- III. [EPO](#)
- IV. [Non-Invasive Vascular Studies](#)
- V. [Blood](#)
- VI. [Billing](#)
  - a. Type of Bill UB-04/837I Form Locator 4
  - b. Line Item Date of Service UB-04/837I Form Locator 45
  - c. Condition, Occurrence, Occurrence Span and Value Codes UB-04/837I Form Locators 18-41
  - d. Revenue Codes UB-04/837I Form Locator 46

## **I. GENERAL GUIDELINES**

### **A. Collecting For Services**

Center will not charge the member for services prior to them being provided except for deductible and coinsurance amounts or non-covered services.

- Up front collection of these amounts is the provider's decision. BCBSKS does not have a policy that requires providers to collect up front.
- If the member has already satisfied part of their deductible, coinsurance or share payment, providers can only bill up front for the balance.
- Member responsibility must be calculated based on the BCBSKS MAP or allowance and not on the total charge.
- If the up front collection results in an overpayment that is due the patient, a refund must be made to them timely.

### **B. Medical Unnecessary/Experimental/Investigational Services**

Centers will not bill the member for services that are medically unnecessary or experimental/investigational unless the member was notified prior to the services being provided. Refer to section titled PRIOR AUTHORIZATION/PRECERTIFICATION of ADMISSIONS/SERVICES for complete details about the Notice of Personal Financial Obligation.

### **C. Claim Submission**

Claims will be submitted within 15 months from the date of the outpatient service.

If BCBSKS requests additional information or clarification about a claim before it can be processed, the provider will submit this information within 15 months of the date of service.

Corrected claims of adjustment requests must also be filed within 15 months of the date of service.

### **D. Uncompleted Treatments and “No-shows”**

Uncompleted Treatments – If a dialysis treatment is started (i.e., a patient is connected to the machine and a dialyzer and blood lines are used) but the treatment is not completed for some unforeseen, but valid reason (e.g., a medical emergency when the patient must be rushed to an emergency room) the facility is paid based on the full composite rate. This should be a rare occurrence, and must be fully documented to BCBSKS satisfaction.

No-shows – If a facility sets up in preparation for a dialysis treatment, but the treatment is never started, e.g., the patient never arrives, no payment is made. In this case, no services have been furnished to a patient even though staff time and supplies may have been used. Furthermore, the facility may not bill the patient for these services.

## **E. Blue Cross Billing**

Reimbursement for dialysis encounters is based on a composite rate which includes components similar to those identified by Medicare, including but not limited to, routine pharmacy, laboratory services and all supplies. While Blue Cross follows the composite rate reimbursement identified by Medicare, this does not guarantee that every contract held by a member will include benefits for these services. Contact Customer Service to verify benefits on each member's Blue Cross policy.

Blue Cross allows for Method I and II (home dialysis support services) billing for institutional claims. Coding of the claim will follow the same basic format described by Medicare.

**Note:** On occasion, Medicare may restrict the use of certain codes (i.e. J0886) however, if the code is still valid, BCBSKS will allow its use.

Services billed at frequencies above and beyond those stated in the Medicare program will be denied by Blue Cross unless there is medical justification for the service. (i.e. lab services included in the composite rate, drugs included in the composite rate, etc.) These services may be identified during routine post-pay reviews. If you receive a notice for refund you will need to submit records stating medical justification to support the service billed.

## **F. Medical Records**

When requested, complete medical record information will be provided in a format that can be utilized by BCBSKS.

The members contract allows BCBSKS to request and receive medical record information without the need for additional authorization.

## **G. Outpatient pharmacy**

Outpatient oncology drugs, outpatient chemotherapy and other designated outpatient pharmacy must be billed with HCPCS codes. Reimbursement for the drug is based on the codes billed and subject to a payment limit. During the year if new codes are created, the same reimbursement methodology will be applied.

The maximum allowable payment (MAP) for each code will be established annually, but adjusted during the year only if the packaging or volumes that make-up the code changes significantly.

Refer to the Policies and Procedures Payment Attachment for complete details relating to average wholesale price and maximum allowable costs for outpatient pharmacy reimbursement.

## II. Composite Rate

The cost of certain ESRD services that are routinely performed as part of outpatient dialysis treatment are included in a single payment rate called a composite rate.

- Items included under the composite rate are NOT separately billable.
- The cost for these services are included in the charge for dialysis services.
- If a facility fails to furnish (either directly or under an arrangement) any part of the services covered under the rate, payment cannot be made for any part of the services that were furnished.

Services that are excluded from the composite rate are those services either:

- Not routinely provided as part of outpatient dialysis treatment; OR
- Tests provided more frequently than normal for dialysis patients

When a service is excluded from the composite rate, the service may be billed separately. However, the service must also meet medical necessity. The medical necessity of the service must be documented in the patient's medical record and included in the ICD-9-CM diagnosis code, which is included on the claim.

### A. Other Routine Items and Services

Unless specifically stated otherwise, the cost of all dialysis items, services and supplies are covered and included under the composite rate and must be furnished by the facility, either directly or under arrangements, to all of its patients. If the facility fails to furnish any part of the items or services covered under the rate, the facility cannot be paid any amount for the part of the item or services that it does furnish. Example of these items and services include, but are not limited to:

- Medically necessary dialysis equipment
- Home dialysis support services including the delivery, installation, maintenance, repair and testing of home dialysis and support equipment.
- Purchase and delivery of all necessary dialysis supplies
- ESRD related laboratory tests
- All dialysis services furnished by the facility's staff (i.e. ultrafiltration, hemodialysis access flow study)
- Staff time used to administer blood
- Dec clotting (flushing) of shunts and any supplies used
- Oxygen and its administration
- Staff time used to administer separately billed parenteral items
- Staff time used to collect specimens for all laboratory tests
- Dialysate additives (e.g., Bicarbonate)
- Cardiac monitoring
- Catheter change (Ideal loop)
- Suture removal
- Dressing changes
- Crash cart usage for cardiac arrest
- Bandages

## **B. Composite Rate - Laboratory**

Costs of certain ESRD laboratory services performed by either your own dialysis staff or by an independent laboratory (by arrangement) are included in the composite rate payment calculation.

### **Rules for Laboratory Services Included in the Composite Rate:**

- Laboratory Test routinely performed for outpatient dialysis patients
- No additional documentation of medical necessity is required
- Specimen collection is included in the composite rate for any patient dialyzed in an ESRD facility
- When any of these tests are performed at a frequency greater than specified, the additional laboratory tests are separately billable and covered IF the documentation supports the medical necessity.

### **Separately Billable Laboratory Services**

- Includes all ESRD-related laboratory tests not covered under the composite rate
- Medical necessity documentation is required when:
- The laboratory test is not included in the composite rate (not listed)
- All tests previously listed as covered under the composite rate when performed at a frequency greater than specified

### **Laboratory Tests Provided by ESRD Facility**

- Routine laboratory tests that are included under the composite rate should (NOT to be billed separately)
- Laboratory tests that fall outside the composite rate (excluded) (should be billed separately)

### **LABORATORY TESTS PROVIDED BY INDEPENDENT LABORATORY**

When the laboratory test is INCLUDED under the composite rate:

- The independent laboratory bills the ESRD facility
- The service is included in the composite rate and is NOT billed separately

When the laboratory test is EXCLUDED from the composite rate:

- The Independent laboratory may bill for the laboratory service.

### **LABORATORY SERVICES INCLUDED IN THE COMPOSITE RATE**

- Intermittent Peritoneal Dialysis and CCPD

Per Treatment – All hemotocrit, hemoglobin, and clotting time tests furnished incident to dialysis treatments;

Weekly – (1) Prothrombin time for patients on anticoagulant therapy, and (2) Serum Creatinine;

Weekly or Thirteen Per Quarter – BUN;

Monthly – Serum Calcium, Serum Potassium, Serum Chloride, CBC, Serum Bicarbonate, Serum Phosphorous, Total Protein, Serum Albumin, Alkaline Phosphatase, aspartate amino transferase (AST) (SGOT) and LDH; and

Automated Battery of Tests – If an automated battery of tests, such as the SMA-12, is performed and contains most of the tests listed in one of the weekly or monthly categories, it is not necessary to separately identify any tests in the battery that are not listed.

- CAPD

Monthly

Total Protein

BUN	Albumin
Creatinine	Phosphatase
Sodium Alkaline	LDH
Potassium	AST, SGOT
CO2	HCT
Calcium	Hgb
Magnesium	Dialysate Protein
Phosphate	

**LABORATORY SERVICES EXCLUDED FROM THE COMPOSITE RATE (SEPARATELY BILLABLE)**

- Hemodialysis, IPD, CCPD, and Hemofiltration

Serum Aluminum – one every three months.

Serum Ferritin – one every three months.

- CAPD

Every 3 months

WBC

RBC

Platelet count

Every 6 months

Residual renal functions

24 hour urine volume

**C. DRUGS**

**Routine Drugs**

Certain parenteral items used in the dialysis procedure are covered under the composite rate and may not be billed separately. Drugs that are used as a substitute for any of these items, or are used to accomplish the same effect, are also covered under the composite rate. For home patients choosing Method II payments, these items may be covered without documentation for medical necessity and may be billed by an ESRD facility regardless of where they are furnished. Following is a list of these items:

- Antiarrhythmics
- Antibiotics (when used at home by a patient to treat an infection of the catheter site or peritonitis associated with peritoneal dialysis)
- Antihistamines
- Antihypertensives
- Apresoline (hydralazine)
- Benadryl/Dopamine
- Glucose Dextrose
- Heparin
- Heparin antidotes
- Hydralazine
- Inderal
- Insulin
- Lanoxin
- Levophed
- Lidocaine
- Local Anesthetics
- Mannitol
- Pressor drugs
- Protamine
- Saline
- Solu-cortef
- Verapamil

The administration of these items (both staff time and supplies) is covered under the composite rate and may not be billed separately. Self-administered items are not covered under the Medicare program, with the exception of EPO.

\*Albumin may be reasonable and medically necessary for the treatment of certain complications in dialysis patients. In such cases, facilities must submit medical justification (ICD-9-CM code) to show the medical need. If BCBSKS approves, separate payment in addition to the composite rate may be made. However, if albumin is used as a substitute for any parenteral item covered under the composite rate (e.g., as a volume expander), payment for it is included in the facility's composite rate for maintenance dialysis.

**Non-routine Drugs**

The following categories of drugs (including but not limited to) are separately billable when provided in the dialysis facility to treat the patient's renal condition:

- Anabolics
- Analgesics
- Antibiotics
- Hematinics
- Muscle Relaxants
- Sedatives
- Thrombolytics\*
- Tranquilizers

\*Thrombolytics are used to declot central venous catheters (effective for services performed on or after 01/16/94).

These items may only be billed by an ESRD facility if they are actually administered in the facility by facility staff. Staff time used to administer separately billable parenteral items is covered under the composite rate and may not be billed separately

### **III. EPOETIN (EPO)/Darbepoetin Alfa (ARANESP)**

EPO is covered for the treatment of anemia for patients with chronic renal failure who are on dialysis when:

- ❖ It's administered at the renal dialysis facility, or
- ❖ It is administered by a home dialysis patient or patient caregiver who is determined competent to use the drug and meets the other criteria.
- ❖ Erythropoietin replacement therapies (ie. EPO/Aranesp) are separately billable drugs and are payable in addition to the composite rate reimbursement.

Separate payment will not be made by BCBSKS for supplies used to administer EPO.

### **IV. Non-Invasive Vascular Studies**

Non-invasive vascular studies, including duplex and doppler flow scans, for the purpose of monitoring the patient's vascular access site should not be billed separately.

The technical portion of these non-invasive vascular studies is included in the composite rate.

### **IV. Blood Services**

Fees charged to the ESRD facility by the blood bank/supplier for blood processing services (e.g., blood typing, crossmatching) and charges for supplies used to administer blood are reimbursed in addition to the composite rate. Facility staff time used to perform services in the dialysis unit, including time to administer blood, is included in the composite rate and may not be billed separately. Blood storage and processing should be billed using revenue code 39X.

### **VI. Billing**

- A. Type of Bill UB-04/837I Form Locator 4  
072X Clinic – Hospital Based or Independent Renal Dialysis Center

The fourth digit defines the frequency:

- XXX1 Admit through discharge claim
- XXX2 Interim – first claim
- XXX3\* Interim – continuing claim
- XXX4\* Interim – final claim
- XXX7 Replacement claim
- XXX8 Cancelled claim

\*Interim billing is accepted but not required.

- B. Line Item Dates of Service UB-04/8371 Form Locator 45  
ESRD facilities must report HCPCS codes and units to bill for blood and blood products, and to bill for drugs and clinical diagnostic laboratory services paid outside the composite rate.

Line item dates of service are to be reported for every line where a HCPCS code is required on all outpatient claims, including claims where the from and through dates are the same.

- C. Condition, Occurrence, Occurrence Span and Value Codes UB-04/8371 Form Locators 18-41  
All condition, occurrence, occurrence span and value codes will be accepted on the Blue Cross claim, but only the ones listed below will be used to determine member benefits and provider payment.

Condition Code 73

Condition code 73 is used to report dialysis self care training.

Condition Code 76

Condition code 76 is used to report a home dialysis patient that received back-up dialysis in a facility.

Value Code 68 – Number of units of EPO administered and/or furnished during the billing period.

Effective June 1, 2007

BCBSKS no longer requires this code.

NOTE: Billing instructions for EPO units appears later in the section. See revenue code 0636.

Prior to June 1, 2007

Value code 68 is used to report the number of units of EPO administered or supplied during the billing period. This code is used to make payment for the drug EPO. If EPO is billed and value code 68 does not appear on the claim, it will be returned to you.

**D. Revenue Codes UB-04/837I Form Locator 46**

REVENUE CODE STRUCTURE		
027X	MEDICAL/SURGICAL SUPPLIES AND DEVICES	Supplies are part of the composite rate and should not be separately billed to BCBSKS. IF they are billed to BCBSKS, no additional payment will be allowed.

REVENUE CODE STRUCTURE		
038X	BLOOD and BLOOD COMPONENTS	RATIONALE: Charges for blood must be separately identified for private payer purposes.
Note:		
1.	This revenue code category is used when the provider actually purchases blood products from another entity.	
2.	HCPCS is required.	
3.	Units should indicate the number of units transfused during the billing period.	
4.	Most Blue Cross contracts do not cover whole blood.	
5.	Report charges only for the blood product. Administration charges would be billed under revenue code 0391.	
Subcategory		
		Standard Abbreviation
0380	General Classification	BLOOD & BLOOD COMP
0381	Packed Red Cells	BLOOD/PKD RED
0382	Whole Blood	BLOOD/WHOLE
0383	Blood Plasma	BLOOD/PLASMA
0384	Blood Platelets	BLOOD/PLATELETS

0385	Blood Leukocytes	BLOOD/LEUCOCYTES
0386	Blood-Other Components	BLOOD/COMPONENTS
0387	Blood-Other Derivatives	BLOOD/DERIVATIVES
0389	Other Blood and Blood Components	BLOOD/OTHER
039X	BLOOD STORAGE AND PROCESSING	Code indicates charges for the storage and processing of whole blood.
Notes:		
1.	Providers who receive blood and blood products from a blood supplier (e.g., Red Cross), should bill for the administration charge as well as for the blood storage and processing charge.	
2.	For administration, use revenue code 0391 with CPT 36430. Units equal one per encounter during which a blood product was administered.	
3.	For the blood or blood product the charge you have to report is for storage and processing. Report revenue code 0392. (new code effective 3/07).	
	Even though you are not reporting an actual charge for the blood or blood product, you must report the HCPCS of the blood item for which there are storage and processing charges.	
	Units should be the number of units transfused.	
Category		Standard Abbreviation
0390	General Classification	BLOOD/ADMIN/STOR
0391	Administration (e.g., transfusion)	BLOOD/ADMIN
0392	Processing and Storage	BLOOD/STORAGE
0399	Other Blood Handling	BLOOD/ADMIN/STOR/OTHER

**REVENUE CODE STRUCTURE**

063X	DRUGS REQUIRING SPECIFIC IDENTIFICATION	Code indicates charges for drugs and biologicals requiring specific identification as required by the payer.
------	---	--

**Notes:**

1. HCPCS required
2. Units equal the number of doses given based on the HCPCS definition (i.e. if the dose given is 10mg and the HCPCS code is for 5mg, enter 2 as the units.)
3. See instruction below for EPO.

Category	Standard Abbreviation
0630 General Classification	DRUGS
0634 Epoetin (EPO) less than 10,000 units	DRUG/EPO < 10,000 UNITS
0635 Epoetin (EPO) 10,000 or more units	DRUG/EPO > 10,000 UNITS
0636 Drugs Requiring Detailed Coding	DRUGS/DETAIL CODE

**Billing For EPO**

1. 634-the administration of less than 10,000 units of EPO  
635-the administration of 10,000 or more units of EPO
2. Units based on the CPT/HCPCS code definition.
3. Report value codes:  
49-Hematocrit Reading = the latest hematocrit reading taken prior to the last administration of EPO during the billing cycle related to the use of EPO.  
68 – the TOTAL number of units of EPO administered in this billing period. Effective 6/1/07 BCBSKS no longer requires this value code. Prior to this date this code was required.

**REVENUE CODE STRUCTURE**

082X	HEMODIALYSIS - OUTPATIENT OR HOME DIALYSIS	Code indicates a necessary waste removal process performed in an outpatient or home setting when the body's own kidneys have failed. Waste is removed directly from the blood.
------	--	--

NOTE: Do not use the revenue code to indicate sessions under METHOD II. However, backup dialysis furnished to home patients in the facility may be billed. (See condition code 76.)

1. The units reported with revenue code 0821 should equal the number of dialysis sessions that occurred during the billing period.
  
2. Use condition code 73 in addition to revenue code 821 when providing self training.
  
3. Routinely provided in three sessions weekly. Medical records may be requested for sessions that exceed this threshold.

Subcategory	Standard Abbreviation
0820 General Classification	HEMO/OP OR HOME
0821 Hemodialysis/Composite	HEMO/COMPOSITE
0822 Home Supplies	HEMO/HOME/SUPPL
0823 Home Equipment	HEMO/HOME/EQUIP
0824 Maintenance/100%	HEMO/HOME/100%
0825 Support Services	HEMO/HOME/SUPSERV
0829 Other Hemodialysis Outpatient	HEMO/OTHER OP

**REVENUE CODE STRUCTURE**

083X	PERITONEAL DIALYSIS- OUTPATIENT OR HOME	A waste removal process performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed indirectly by flushing a special solution between abdominal covering and the tissue.
<p>NOTE: Do not use the revenue code to indicate sessions under METHOD II. However, backup dialysis furnished to home patients in the facility may be billed. (See condition code 76.)</p>		
<ol style="list-style-type: none"> <li>1. The units reported with revenue code 0831 should equal the number of dialysis sessions that occurred during the billing period.</li> <li>2. Use condition code 73 in addition to revenue code 831 when providing self training.</li> <li>3. Routinely provided in three sessions weekly. Medical records may be requested for sessions that exceed this threshold.</li> </ol>		
Subcategory		Standard Abbreviation
083X	General Classification	PERITONEAL/OP OR HOME
0831	Peritoneal/Composite	PERTNL/OP/COMPOSITE
0832	Home Supplies	PERTNL/HOME/SUPPL
0833	Home Equipment	PERTNL/HOME/EQUIP
0834	Maintenance/100%	PERTNL/HOME/100%
0835	Support Services	PERTNL/HOME/SUPSERV
0839	Other Peritoneal Dialysis	PERTNL/HOME/OTHER

**REVENUE CODE STRUCTURE**

084X	CONTINUOUS AMBULATORY PERITONEAL DIALYSIS (CAPD)-OUTPATIENT or HOME	A continuous dialysis process performed in an outpatient or home setting, using the patient's peritoneal membrane as a dialyzer.
------	---	--

NOTE: Do not use the revenue code to indicate sessions under METHOD II. However, backup dialysis furnished to home patients in the facility may be billed. (See condition code 76.)

1. The units reported with revenue code 0841 should equal the number of dialysis sessions that occurred during the billing period.
2. Use condition code 73 in addition to revenue code 0841 when providing self training.

Subcategory	Standard Abbreviation
0840 General Classification	CAPD/OP OR HOME
0841 CAPD/Composite	CAPD/COMPOSITE
0842 Home Supplies	CAPD/HOME/SUPPL
0843 Home Equipment	CAPD/HOME/EQUIP
0844 Maintenance – 100%	CAPD/HOME/100%
0845 Support Services	CAPD/HOME/SUPSERV
0849 Other Outpatient CAPD	CAPD/HOME/OTHER

085X	CONTINUOUS CYCLING PERITONEAL DIALYSIS (CCPD)-OUTPATIENT OR HOME	A continuous dialysis process performed in an outpatient or home setting, using the patient's peritoneal membrane as a dialyzer.
<p>NOTE: Do not use the revenue code to indicate sessions under METHOD II. However, backup dialysis furnished to home patients in the facility may be billed. (See condition code 76.)</p>		
<p>1. The units reported with revenue code 0851 should equal the number of dialysis sessions that occurred during the billing period.</p>		
<p>2. Use condition code 73 in addition to revenue code 0851 when providing self training.</p>		
Subcategory		Standard Abbreviation
0850	General Classification	CCPD/OP OR HOME
0851	CCPD/Composite	CCPD/OP/COMPOSITE
0852	Home Supplies	CCPD/HOME/SUPPL
0853	Home Equipment	CCPD/HOME/EQUIP
0854	Maintenance/100%	CCPD/HOME/100%
0855	Support Services	CCPD/HOME/SUPSERV
0859	Other CCPD Dialysis	CCPD/HOME/OTHER

**REVENUE CODE STRUCTURE**

086X	RESERVED	
087X	RESERVED	
088X	MISCELLANEOUS DIALYSIS	
Subcategory		Standard Abbreviation
0880	General	
0881	Ultrafiltration	