Kidney Health Care (KHC)
Provider Manual

April 2023

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Introduction

Welcome to Kidney Health Care (KHC). This provider manual is designed to answer questions you may have as a provider of our program. It is separated into three sections:

- Your rights and responsibilities as a provider
- The various benefits available to KHC clients
- How to file claims for processing

If you have questions regarding this manual, program benefits or need client-related information, contact KHC by phone at 800-222-3986, or by email at khc@hhs.texas.gov.

For provider enrollment information, contact Texas Medicaid & Healthcare Partnership (TMHP) at 800-925-9126 or Provider.Relations@tmhp.com , Monday through Friday from 7:00 a.m. to 7:00 p.m. Central Standard Time.

Thank you for participating in KHC and for providing the highest level of care to Texans in need.

Provider Enrollment
Kidney Health Care

Provider Enrollment – KHC
Mail Code 1938
PO Box 149030
Austin, TX 78714-9947

Toll Free: 800-222-3986
Fax: (512) 206-3982

Chapter 1: Overview of the Kidney Health Care Program

The Kidney Health Care Program improves access to health care by providing a source of limited benefits for eligible Texas residents with end stage renal disease (ESRD).

History of Kidney Health Care

In April of 1973, the Kidney Health Care Act established the KHC Program in Texas. In passing the act, the state recognized that patients with chronic kidney disease have a higher mortality rate when they lack the income or resources to pay for care. Vulnerable populations, such as the impoverished or uninsured, are solely responsible for the high cost of care and must choose to forgo vital treatments to pay for daily needs. Individuals with ESRD who qualify for Medicare face similar challenges in the 90 days before their benefits begin. KHC exists to help Texans in these situations gain access to life-saving medications and care.

The KHC Program operates under Texas Administrative Code, Title 26, Par 1, Chapter 365.

KHC Benefits

KHC benefits are funded by state legislated subsidies. They are disbursed to eligible participants based on factors such as treatment type, Medicare, and the time of treatment.

KHC clients may receive some—or all—of the following program benefits:

Medical

KHC medical coverage helps clients with the cost of access surgery and dialysis treatments until Medicare benefits begin.

Drugs

KHC prescription drug coverage assists clients with out-of-pocket costs for ESRD-related drugs, including immunosuppressive medications for kidney transplant recipients.

Premium Payment Assistance

KHC pays Medicare Part D premiums for clients, and in some circumstances, a portion of client premiums for Medicare Parts A & B.

Travel

KHC travel benefits offset the trip cost of commuting to and from dialysis treatments or other ESRD-related medical visits. Providers submit travel claims on behalf of KHC clients who receive dialysis in a facility. Home peritoneal and transplant clients file their own travel claims.

Client Eligibility Criteria

Applicants must meet all the following criteria to be eligible for KHC:

- be a Texas resident;
- have a diagnosis of ESRD certified by a physician;
- have a combined gross annual income of less than $60,000;
- be receiving regular dialysis treatments or have received a kidney transplant; and
- have applied, or are currently applying, for Medicare based on a diagnosis of ESRD.

Applicants are ineligible for coverage if they are:

- Medicaid recipients (Medicaid benefits include prescription drug, transportation, and medical coverage.)
- A ward of the state or are incarcerated in a city, county, state or federal jail or prison.

Only dialysis facilities or medical providers enrolled with KHC can submit applications on behalf of clients. Applications are submitted by fax or mail.

Chapter 2: Provider Enrollment

Texas Medicaid & Healthcare Partnership (TMHP), on behalf of Accenture Services, operates the Provider Enrollment Management System (PEMS), a database that contains all provider enrollment information for KHC. TMHP is responsible for provider enrollment and data management. As of August 15, 2022, all KHC providers are required to enroll in the PEMS system.

TMHP enrolls various provider types including outpatient dialysis facilities, physician groups, individual physicians, Certified Registered Nurse Anesthetists (CRNAs), hospitals, Ambulatory Surgical Centers (ASCs), pharmacies, and stand-alone Medicare Prescription Drug Plans in Texas. Military hospitals may enroll in KHC but are not eligible for payments.

KHC providers must enroll, re-enroll, and revalidate with HHSC through PEMS as of August 15, 2022.

TMHP provides PEMS computer-based training modules on the TMHP Learning Management System (LMS). A LMS account, including a username and password, is required to access training courses. Instructions on creating an LMS account are available on the TMHP LMS Account Login web page. Refer to the TMHP Online Resources section for more information.

Enrollment of Texas Medicare Prescription Drug Plans

Stand-alone Texas Medicare Prescription Drug Plans (PDPs) partner with KHC to offset premium costs for enrollees. For more information about our prescription drug plan application contact TMHP at 800-925-9126 or visit tmhp.com.

For a copy of the Texas KHC PDP Provider Manual, contact SHProviderRelations@hhs.texas.gov.

Change of Ownership (CHOW)

A change of ownership (CHOW) is the sale, dissolution, or trade of business to a new owner, parent company, corporation, or group. If an enrolled provider changes ownership, the purchased provider must notify TMHP immediately. Any outstanding balances owed to the program at that time are due by the entity that legally

assumes liability for the amount. A CHOW cannot be initiated until verification and payment have been received.

Reasons for Suspension or Termination of Enrollment

TMHP or KHC may suspend or terminate a provider's enrollment status for any of the following reasons:

1. Providing false or misleading information;
2. Filing false or fraudulent information or claims;
3. Disenrollment or exclusion from the Medicare program;
4. A material breach of any contract or agreement with KHC or TMHP;
5. Failure to submit a payable claim to the program within a 365-day rolling period; or
6. Failure to maintain participation criteria as outlined during enrollment

A provider may appeal a suspension or termination through the administrative review and fair hearing process described in the Provider Rights chapter of this provider manual.

Chapter 3: Provider Responsibilities

KHC providers must follow the KHC Program Rules as outlined in the Texas Administrative Code and all responsibilities expressed in the TMHP provider agreement.

Requirements

Providers must:

1. Be aware that any false claims, statements, documents, or concealment of material fact, may be prosecuted under applicable state and federal laws.
2. Be aware that KHC will recoup any overpayments to the provider for medical claims.
3. Not discriminate against an individual on the basis that the person is a KHC client.
4. Identify KHC clients who demonstrate limited English proficiency to ensure they are provided with the necessary language assistance and have equal access to KHC services.
5. Report temporary closures of their facility within 30 business days.
6. Report changes in any of the following to TMHP within 30 business days:
    A. Name
    B. Address
    C. Ownership
    D. Acting Agents
        a. Office Manager
        b. Social Worker
        c. Administrator
        d. Payment
        e. Contract
        f. Billing
        g. Owner
        h. Other

E. DSHS Licensing

F. Tax Information

G. Status of Medicare, Medicaid or other required license and certifications.

How to Report Changes

Providers are required to report changes to their contacts, addresses, etc., within 30 days of the change to TMHP.

Filing Claims

Providers must file all claims within program guidelines.

- See section titled "Submission of Client Applications and Travel Claims" for details on filing travel claims. This section can be found in Chapter 5.
- See chapter titled "Chapter 7: Medical Benefits and Claims Filing" for details on filing medical claims.

Social Workers

KHC clients who attend dialysis and hospital providers interact with the program through social workers. As an enrolled entity, KHC providers are required to ensure their staff comply with all program rules as well as the responsibilities expressed in the provider agreement when serving KHC clients. Facility social worker tasks include, but are not limited to:

- Screening patients for KHC eligibility.
- Submitting completed KHC client application forms to the program by mail or fax:

  Health Kidney Health Care
  Mail Code 1938
  PO Box 149030
  Austin, TX 78714-9947
  Fax: (512) 206-3982

- Explain KHC benefits and limitations to applicants. The program has created a resource to assist prospective enrollees: it is available in both English and Spanish. Download it now using the links or find it online at Forms | Texas Health and Human Services.

- Help KHC clients research and apply for health coverage through auxiliary programs, such as Medicare, low-income subsidies, Medicaid, and others.
- Retain records related to KHC client applications and travel claims for a minimum of five (5) years, including:
    - A physical or digital copy of original KHC application;
    - Physical or digital copies of supporting verification provided with the application; and
    - All physical and digital data related to travel claims submitted for payment.
- The program or client may, at any time, request all records pertaining to individual services, claims, and applications. As an enrolled provider, you are required to give full, no-cost access and photocopies.
- Outpatient dialysis facilities must verify and submit monthly travel reports on behalf of eligible clients as outlined in Section "Submission of Client Applications, Updates and Travel Claims", found in Chapter 5.
- Immediately notify the program if a client:
    - Is deceased.
    - Becomes a ward of the state.
    - Becomes eligible for Medicaid coverage.
    - Regains kidney function or voluntarily stops treatment for ESRD.
    - Becomes incarcerated in a city, county, state or federal jail or prison.
    - Receives healthcare benefits through any entity or program, public or private.
    - Experiences a change in income or financial status that may affect eligibility.
- Prior to filing a medical and/or travel claim, notify the program of any of the following client changes:
    - Permanent physical or mailing address.
    - Modality (e.g., hemodialysis, peritoneal dialysis, transplant).
    - Insurance coverage (including Medicare).
    - Treatment facility change.
    - Round-trip mileage to treatment location.
    - Mode of transportation to the dialysis facility, such as an ambulance.

KHC Training Opportunities

KHC encourages all providers to complete our online training course, titled KHC 101: What Every Social Worker Should Know. This free, self-paced course is a comprehensive look at the program and client eligibility, how to submit travel claims, the benefit types, as well as client and provider responsibilities. The course offers continuing education credit for social workers and is a prerequisite for all additional trainings. For information on how to enroll, contact the OPSH Training Resources & Services Group at SH.TrainingServices@hhs.texas.gov

Chapter 4: Provider Rights

Program providers have a right to:

- Know the status of applications they submit to Program on behalf of their client. The Notice of Eligibility (NOE) they will receive will contain either a specific date on which eligibility for Program benefits will begin or an explanation of why Program denied the application.
- Expect OPSH to make a determination regarding the eligibility for Program benefits for any client seen at their facility for whom they have submitted an application.
- Submit a request for an administrative review on behalf of a Program client seen at their facility who has been denied eligibility for services. This will be discussed in detail in the "Administrative Review and Fair Hearing" section below.
- Additionally, all providers who are enrolled in Program have a right to:
  - An administrative review in the event Program:
    - ◊ denies a claim.
    - ◊ suspends the provider's approval to participate in Program.
    - ◊ terminates the provider's approval to participate in Program.
  - A Fair Hearing if the provider disagrees with the outcome of the Administrative Review.

Administrative Review and Fair Hearing

A client or provider who receives an adverse decision can request an administrative review. If Program upholds the original decision, the provider can request a fair hearing.

Adverse decisions that an applicant or client can receive pertain to:

- denial of Program eligibility.
- denial of benefit payment.

Adverse decisions that a provider can receive include:

- denial of claim payment.

- termination of enrollment.

The Notice of Eligibility (NOE), Explanation of Benefits (EOB), or provider termination letter indicates how to request an administrative review and will include the address or fax to submit a written request, and the phone number to call for assistance in requesting an administrative review.

The request for an administrative review must be made within 30 business days of the date on the correspondence that indicates the adverse decision. Failure to do so will result in the waiver of the client's or provider's right to an Administrative Review and the Program action will become final.

Administrative Review Process

The Administrative Review process is as follows:

- Program notifies the affected party (the applicant, client, or provider) of his or her right to request an Administrative Review on the NOE, EOB or the termination letter.
- The affected party has 30 business days from the date of the notice to request an administrative review and include supporting documentation.
- Program accepts a request for an administrative review in writing via fax or mail from a client, social worker or any agent acting on behalf of the affected party. Providers and clients can also call Program at 800-222-3986 and a customer service representative will assist them in requesting the administrative review.
- Program conducts a comprehensive review of the request, using all available documentation.
- Program sends the affected party an administrative review response letter with the decision to uphold, partially overturn or completely rescind Program's prior decision within 30 calendar days of receipt. Program may send an extension notice by the 30th calendar day informing the affected party that more time is required. Extension determination is at Programs discretion.
- The Administrative Review response letter will include:
  - the action Program intends to take, and
  - an explanation of the reasons for the action.
- If Program does not completely overturn its prior decision, the administrative review response letter will also include:

    - an explanation of the client or provider's right to request a fair hearing
    - the procedure to request a fair hearing
    - the address or fax to submit the written request.
- The affected party has 20 calendar days from the date of the administrative review response letter to request a fair hearing. (See below.)
- If the affected party does not respond within 20 calendar days from the date of the administrative review response letter, the right to a fair hearing will be considered waived and the action taken by Program will be considered final.

Fair Hearing Process

The Fair Hearing process is as follows:

- The affected party must request a fair hearing in writing within 20 calendar days from the date of the administrative review response letter. The request must state the reasons for the disagreement with Program's decisions and include any documents or other proof that help support those reasons.
- Program will forward the fair hearing request to the Office of General Counsel for Contested Cases at HHS.
- The HHS Office of Chief Counsel will then schedule the hearing with the hearing examiner.
- The hearing examiner is responsible for the fair hearing from that point on.

Chapter 5: Submission of Client Applications

Updates and Travel Claims for Dialysis Facilities and Hospitals

Dialysis facilities and hospitals enrolled in KHC can submit the KHC Program Application for benefits, client updates, and client travel claims.

- Facilities may submit KHC applications via mail or fax at 512-206-3982.
- Facilities may submit updates and travel claims via regular mail or fax.

Submission of Client Applications

KHC will only accept the client application for benefits from KHC-enrolled providers.

The Kidney Health Care Program Application is located on the KHC website under "Download Forms and Publications" in the menu on the left side.

A complete KHC application requires an application form with all fields completed, and along with the documents listed below. All documents must be in English or accompanied by an accurate English translation.

- End Stage Renal Disease Medical Evidence Report (CMS-2728 Form), or KHC Physician Assessment Form
- Social Security Document
- Residency Document
- Income Verification Document

The application with all the supporting documents attached must be signed and dated by the applicant. Original signatures are no longer required. The provider must submit the complete application to KHC via mail or fax.

Complete applications must be submitted to avoid delays in application processing. KHC will return incomplete applications to the provider. KHC will be available to assist providers if they have trouble completing an application.

Providers must retain a copy of the original paper application they send to KHC or retain the original paper document that corresponds to all applications submitted and copies of supporting documentation for at least seven (7) years.

Submission of Client Updates and Travel Claims

All facilities, regardless of their enrollment status, must follow these filing guidelines:

- Submit any updates to client information before submitting travel claims for that month.
    - Updates must occur before entering travel claims for the client or the claims will be processed incorrectly.
    - Facilities that submit client updates and travel claims on paper can submit both forms simultaneously and KHC will process them appropriately.
- KHC will only accept travel claims for dialysis clients from the dialysis facility in the client record on or after the first of the month following the dates of service (for example, July travel claims are processed beginning August 1).
- Facilities must submit updates and travel claims by mail or fax (contact information can be found in the Introduction of this provider manual).
- Facilities must submit travel claims by the 15th of the month following the month when travel occurred.
- KHC will return the claims submitted on the Monthly Travel Report if the report is received before the end of the service month being reported. Providers will need to resubmit those claims at the appropriate time.

Travel Claim Filing Deadlines

KHC must receive travel claims within 95 calendar days from last day of the month in which services were provided. When the due date falls on a weekend or a state or federal holiday, KHC will extend the deadline to the next business workday.

Limitations to KHC Travel Benefits

There are limits to the KHC Travel Benefit:

- Home peritoneal and transplant clients file their own travel claims.

- In-center hemodialysis clients can only get travel benefits to and from the dialysis facility on record. Therefore, it is critical that facilities or clients let KHC know when a client has changed treatment facilities to avoid interruption in payment of the client's travel claims.
- KHC cannot process incomplete or incorrectly submitted travel claims.
- The benefit depends on the type of treatment the client receives for their end stage renal disease (ESRD) (in-center hemodialysis, home peritoneal dialysis or kidney transplant).
- The benefit is subject to a maximum of $200 per month.
- Travel claims must be submitted according to filing deadlines. (See "Travel Claim Filing Deadlines" above for details).
- Travel is calculated for shortest distance, door-to-door. This means that the final round-trip mileage may be less than what the client reports or what is calculated using Bing Maps Driving Directions.

  For more information on the KHC application, travel benefits and travel claim filing, consult the facility's social worker or the Kidney Health Care 101 training resource.

Chapter 6: Premium Payment Assistance

KHC has benefits to help clients pay their premiums for Medicare Parts A, B and D. This benefit depends on the client's eligibility, other insurance coverage, and type of Medicare enrollment the client has.

Medicare Parts A and B Premium Payment

KHC clients who qualify for the buy-in Medicare program may be eligible for help from KHC to pay for their premiums for Medicare Parts A and B at the rate they are billed. KHC will pay the premiums directly to Medicare after it receives the invoice from the client. KHC does not reimburse clients for premiums they have already paid. To qualify, the client must:

- be over 65 years old;
- not be eligible for Medicaid;
- submit their Medicare invoices to KHC;
- be paying for both Medicare A and B themselves using the "buy-in" option; and
- choose the "direct bill" method for payment (not have their premiums auto-deducted from their social security payment).

Medicare Part D Premium Payment

KHC coordinates with Medicare to help clients with their Medicare Part D premium payments and their co-pays.

- KHC pays up to $35 per month for Texas Stand-alone Medicare Part D monthly premium.
- KHC may assist with copays for Medicare Advantage plans.
- KHC does not pay Medicare late enrollment fees.
- KHC will not help with Medicare Supplemental plans.
- KHC's payment is affected by the low-income subsidy or "extra help" from the Social Security Administration. See section below titled, "Low-Income Subsidy (LIS) and How It Affects KHC's Payments".
- Clients pay any amount above the amount that KHC pays.

- Clients must choose the "direct bill" option for their monthly payment. This allows Part D plan to bill KHC directly for the cost of insurance every month. KHC processes premium payment amounts and pays benefits directly to the client's Part D plan.
- KHC will not reimburse clients for monthly payments they make directly to the Medicare Part D plan.
- KHC will not pay the premium for clients who have the payment automatically deducted from their social security benefit, bank account or credit card account.

Low-Income Subsidy (LIS) and How It Affects KHC's Payments

The Social Security Administration gives "extra help" to those who qualify for assistance. All KHC clients covered by Medicare must apply for LIS. The KHC benefit of $35 per client per month includes the low-income subsidy amount.

Example: If the client receives $10 in assistance from the Social Security Administration, KHC will pay no more than $25 in premium assistance.

Clients can call the Social Security Administration at 800-772-1213 for an application or apply online.

Prescription Drug Plan (PDP) Reference Sheet

KHC's PDP and Benefit Plan Reference Sheet is a quick reference guide for identifying the Texas Stand–Alone Plans enrolled with KHC. It contains plan ID numbers and rates and allows the user to look at Medicare Part D payment amounts. The fact sheet includes:

- The total monthly amount for the plan.
- The amount applied from LIS, by percentage.
- The KHC applied amount.
- The client's responsibility based on plan cost and subsidy rates.

KHC recommends that providers keep a copy of the client's Part D insurance card, acceptance letter from the carrier with the effective date, and acceptance or denial letter from Social Security Prescription Drug Assistance in facility's client record.

Click here for an overview on Medicare's Prescription Drug Plan (PDP) Premium Payment Fact Sheet.

Chapter 7: Medical Benefits and Claims Filing

The KHC medical benefit provides coverage for medical services during the client's pre-Medicare qualifying period or when the client is ineligible for Medicare or any other insurance coverage. KHC clients who can get Medicare or Medicaid cannot get medical benefits through KHC.

Medical Services Covered Under the Medical Benefit

KHC provides payment for limited ESRD-related medical services. KHC clients who are eligible for the medical benefit can receive the following medical services from a KHC participating provider:

- Dialysis treatments.
- Some services associated with access surgery, including re-access and de-clotting procedure codes and charges for:
    - hospital,
    - surgeon and assistant surgeon, and
    - anesthesiologist (or certified registered nurse anesthetist).

Dialysis Treatments

KHC coverage for inpatient and outpatient maintenance dialysis treatments depends on the type of treatment (in-center hemodialysis, home dialysis and post-kidney transplant) that appears on the client's KHC record. Therefore, it is very important that providers report all changes in treatment status to KHC immediately so that claims can be processed appropriately.

The number of treatments KHC can pay for are limited, as shown below:

Inpatient or in-center hemodialysis treatments

- Maximum of 14 treatments per month

Peritoneal dialysis (PD) treatments

- Includes Continuous Ambulatory Peritoneal Dialysis (CAPD), Continuous Cycling Peritoneal Dialysis (CCPD) and Intermittent Peritoneal Dialysis (IPD)

- Maximum of 31 treatments per month

Peritoneal dialysis training

- Maximum of 14 training sessions, within a 60-day period

Payment for dialysis treatments that exceed monthly maximum

KHC may consider covering dialysis treatments for inpatient or in-center hemodialysis beyond the monthly limit of 14, when medically necessary. For KHC to consider payment for the additional treatment, providers must follow this procedure:

- Provider submits a claim for the additional treatment.
- KHC will deny the claim.
- Provider submits a request for an administrative review to get coverage for the additional treatment. (See the "Provider Rights" chapter for details on time limits for requesting an administrative review.)
- Provider includes a signed letter of medical need from the attending physician for the additional treatment and its expected duration.
- KHC will follow the administrative review process to determine payment.

The dialysis medical procedure codes that KHC covers are shown in the table below:

Table 1: Procedure Codes Covered by KHC

Type	CPT Codes	KHC Rate	Maximum
Inpatient/Outpatient Dialysis	90935	$54.53	14 per month
Inpatient/Outpatient Dialysis	90937	$78.59	14 per month
Inpatient/Outpatient Dialysis	90997	$67.90	14 per month
Inpatient/Outpatient Dialysis	90999	$130.69	14 per month
Peritoneal Dialysis	90945	$64.67	31 per month
Peritoneal Dialysis	90947	$93.56	31 per month

Type	CPT Codes	KHC Rate	Maximum
Peritoneal Dialysis Training	90989	$60.98	14 in a 60-day period
Peritoneal Dialysis Training	90993	$60.98	14 in a 60-day period

Rates

KHC pays flat rates for dialysis treatment and training. Please refer to the KHC Dialysis Quick Sheet for current rates.

Access Surgery Services

KHC will pay for covered access surgery performed by a KHC-enrolled provider that occurs in an inpatient or outpatient hospital or an ambulatory surgical center.

- Anesthesiology services may be performed by either physicians or Certified Registered Nurse Anesthetists.

For a list of covered access surgery procedure codes, see the KHC Access Surgery Quick Sheet. The maximum rates for access surgery and related services for each provider type appear on the Access Surgery Quick Sheet.

Retroactivity of access surgery benefits

Because access surgery typically occurs before the patient with ESRD is approved for Medicare or KHC, a client's medical benefits for access surgery are retroactive and can be paid if the surgery happens:

- 180 calendar days or less prior to the client's KHC effective date; and
- On or after the date shown in the "Date applicant became a Texas resident" field on the client's KHC application. Call KHC at 800-222-3986 to confirm that date if needed. The client must have been a Texas resident on the date of the access surgery.

KHC strongly recommends that social workers encourage clients to notify their access surgery providers (hospital or ASC, physician, anesthetist) immediately upon notification of KHC eligibility so these providers can file claims timely for payment.

Failure of the client to promptly notify access surgery providers may result in the client being billed for these services.

Claim Filing and Deadlines

KHC sends an EOB to the provider after processing the provider's claim for medical services. The EOB provides an explanation of the payment or denial of the claim. If an EOB has not been received within 30 business days of filing the claim, the provider should contact the KHC program at 800-222-3986.

Access Surgery

Existing KHC providers can file claims for access surgery as soon as the patient finds out that he or she can get the KHC medical benefit. KHC must receive the claims by the later of:

- 95 calendar days from the last day of the month in which services were provided or
- 60 calendar days from the date on the KHC notice of eligibility for newly approved clients.
- Newly approved KHC providers must ensure that KHC receives their claims:
    - No later than 60 calendar days from the PEMS enrollment date, and
    - No later than 180 calendar days from the date of service.

Inpatient and Outpatient Dialysis Treatment

Providers must submit all outpatient claims on the CMS-1500 paper form by mail. KHC must receive the claims:

- within 95 calendar days from the last day of the month in which services were provided or
- within 60 calendar days from the date on KHC's Notice of Eligibility for newly approved clients or
- within 60 calendar days enrollment in the PEMS system, but no later than 180 calendar days from the date of service.
- Note: Postal registered mail receipts are not accepted as proof of timely filing.

Resubmitting Claims

In cases when providers must resubmit a claim (e.g., an in-center dialysis claim is denied because client's KHC record shows that he or she is a home dialysis patient), providers must adhere to these guidelines:

- Include a copy of the EOB, if applicable.
- Resubmit the claim on the original claim form.
- Include no additional charges for service.

Submit within the regular filing deadline or within 30 business days from the date of the EOB, whichever is later.

How to Complete Medical Claim Forms

The OPSH Claims team accepts the UB-04 (CMS-1450) and the CMS-1500 claim forms. There are certain fields on the forms that must be completed, or the claim will be denied. Also, providers need to use the appropriate ICD-10-CM codes for procedures. The required fields for claims submission are shown in the sections that follow.

Note: The Centers for Medicare & Medicaid Services (CMS) is a federal agency within the U.S. Department of Health and Human Services. Many CMS program related forms are available in Portable Document Format (pdf). Hard copy forms may be available from intermediaries, carriers, state agencies, local social security offices or end stage renal disease networks that service your state.

CMS does not supply the form to providers for claim submission. Blank copies of the form may also be available through office supply stores in your geographic area. Although a copy of that form can be downloaded, copies of the form should not be downloaded for submission of claims, since your copy may not accurately replicate colors included in the form. These colors are needed to enable automated reading of information on the form.

CMS-1500 Required Fields

This form must include the fields shown in this table, and is accepted from the following providers:

- Certified Registered Nurse Anesthetists
- Physicians
- Renal dialysis facility (not hospital-based)

Table 2: CMS-1500 Required Fields

Block No.	Description	Guidelines
1a	**Insured's ID No.**	• Enter the client's nine-digit Social Security Number or KHC client number.
2	**Patient's name**	• Enter the client's last name, first name, and middle initial. If the insured uses a last name suffix (e.g., Jr., Sr.) enter it after the last name and before the first name.
3	**Patient's date of birth Patient's sex**	• Enter numerically the month, day, and year (MM/DD/YYYY) the client was born. Indicate the client's sex by checking the appropriate box. • Only one box can be marked.
5	**Patient's address**	• Enter the client's complete address as described (street, city, state, and ZIP+4 code).
11 11a 11b 11c	**Other health insurance coverage**	• If another insurance resource has made payment or denied a claim, enter the name and information of the insurance company. The other insurance EOB or denial letter must be attached to the claim form. • If the client is enrolled in Medicare, attach a copy of the Medicare Remittance Notice to the claim form.
21	**Diagnosis or nature of illness or injury**	• Enter up to four ICD-10-CM diagnosis codes to the highest level of specificity available. ACS (Ambulatory Surgical Centers) providers are not required to enter diagnosis codes.
24	**(Various)**	• General notes for blocks 24a through 24j: • Unless otherwise specified, all required information should be entered in the unshaded portion. • If more than 6-line items are billed for the entire claim, a provider must attach additional claim forms.
24a	**Date(s) of service**	• Enter the date of service for each procedure provided in a MM/DD/YYYY format. • Grouping is not allowed for services on consecutive days. Provider must enter each individual date of service. • Include only one service month per claim form.
24b	**Place of service**	• Select the appropriate POS code for each service.

Block No.	Description	Guidelines
24d	**Fully describe procedures, medical services, or supplies furnished for each date given**	• Enter the appropriate procedure codes and modifier for all services billed.

UB-04 CMS 1450 Required Fields

This form must include the fields shown in this table, and is accepted from the following providers:

- Inpatient hospital
- Outpatient hospital
- Renal dialysis facility (hospital-based only)

Table 3: CMS 1450 Required Fields

Block No.	Description	Guidelines
1	**Unlabeled**	• Enter the name, street, city, state, ZIP+4 Code, telephone number and 6-digit KHC number of provider rendering services.
3a	**Patient Control Number**	• Optional • Any alphanumeric character (limit 16).

Block No.	Description	Guidelines
4	**Type of Bill (TOB)**	Enter a TOB code. **First Digit - Type of Facility:** 1) • Hospital 3) • Home health agency • Clinic (rural health clinic [RHC], federally qualified health center [FQHC]) • Special facility **Second Digit - Bill Classification (except clinics and special facilities):** 1) • Inpatient (including Medicare Part A) 2) • Inpatient (Medicare Part B only) • Outpatient • Other (for hospital-referenced diagnostic services, for example, laboratories and X-rays) **Third Digit - Frequency:** 0) • Nonpayment/zero claim 1) • Admit through discharge claim 2) • Interim-first claim • Interim-continuing claim • Interim-last claim • Late charges-only claim • Adjustment of prior 7) • Replacement of prior claim
5	**Federal Tax ID Number**	• Enter the federal tax ID number of the billing provider shown in Block No. 1.
6	**Statement Covers Period**	• Enter the beginning and ending dates of service billed.
8b	**Patient Name**	• Enter the client's last name, first name, and middle initial.
9a-9b	**Patient Address**	• Starting in 9a, enter the client's complete address as described • (street, city, state, and ZIP+4 code).

Block No.	Description	Guidelines
10	**Birth Date**	• Enter the client's date of birth (MM/DD/YYYY).
11	**Sex**	• Indicate the client's sex by entering an "M" or "F."
12	**Admission Date**	• Enter the numerical date (MM/DD/YYYY) of admission for inpatient claims; or date of service (DOS) for outpatient claims.
13	**Admission Hour**	• Use military time (00 to 23) for the time of admission for inpatient claims or time of treatment for outpatient claims.
14	**Type of Admission**	Enter the appropriate type of admission code for inpatient claims: 1) Emergency 2) Urgent 3) Elective 4) Newborn (this code requires the use of admission code in Block No. 15) 5) Trauma Center

Block No.	Description	Guidelines
15	**Source of Admission**	Enter the appropriate source of admission code for inpatient claims. **For type of admission 1, 2, 3, or 5:** 1) Physician referral 2) Clinic referral 3) Health maintenance organization (HMO) referral 4) Transfer from a hospital 5) Transfer from skilled nursing facility (SNF) 6) Transfer from another health care facility 7) Emergency room 8) Court/law enforcement 9) Information not available **For type of admission 4 (newborn):** 1) Normal delivery 2) Premature delivery 3) Sick baby 4) Extramural birth 5) Information not available
16	**Discharge Hour**	• For inpatient claims, enter the hour of discharge or death. Use military time (00 to 23) to express the hour of discharge. If this is an interim bill (client status of "30"), leave the block blank.
17	**Patient Status**	• For inpatient claims, enter the appropriate two-digit code to indicate the client's status as of the statement "through" date. • See: "Patient Status" table below.
42-43	**Revenue Codes and Description**	• For inpatient hospital services, enter the description and revenue code for the total charges and each accommodation and ancillary provided. • List accommodations in the order of occurrence and ancillaries in ascending order.

Block No.	Description	Guidelines
44	**HCPCS/Rates**	**Inpatient** • Enter the accommodation rate per day. • Match the appropriate diagnoses listed in blocks 67A through 67Q corresponding to each procedure. If a procedure corresponds to more than one diagnosis, enter the primary diagnosis. • Each service and supply must be itemized on the claim form. **Outpatient** • Outpatient claims must have the appropriate Healthcare Common Procedure Coding System (HCPCS) code. • Each service, except for medical/surgical and intravenous (IV) supplies and medication, must be itemized on the claim form or an attached statement. • If necessary, combine IV supplies and central supplies on the charge detail and consider them to be single items with the appropriate quantities and total charges by dates of service. • Multiple dates of service may not be combined on outpatient claims.
45	**Service Date**	• Enter the numerical date of service that corresponds to each procedure for outpatient claims. Multiple dates of service may not be combined on outpatient claims.
46	**Service Units**	• Provide units of service, if applicable. • For inpatient services, enter the number of days for each accommodation listed. If applicable, enter the number of pints of blood. • When billing for observation room services, the units indicated in this block should always represent hours spent in observation.
47	**Total Charges**	• Enter the total charges for each service provided.

Block No.	Description	Guidelines
47 (line 23)	**Totals**	• Enter the total charges for the entire claim. • Note: For multi-page claims enter "continue" on initial and subsequent claim forms. Indicate the total of all charges on the last claim. Be sure to indicate the page number of the attachment (for example, "page 2 of 3") on line 23 of blocks 42-43.
48	**Noncovered Charges**	• Enter the amount of the total noncovered charges.
50	**Payer Name**	• Enter the health plan name.
51	**Health Plan ID**	• Enter the health plan identification number.
56	**NPI**	• Enter the NPI of the billing provider.
58	**Insured's Name**	• If other health insurance is involved, enter the insured's name.
60	**Insured's Unique ID**	• Enter the client's nine-digit Social Security Number or KHC client number which begins with an 8.
61	**Insured Group Name**	• Enter the name and address of the other health insurance.
62	**Insurance Group Number**	• Enter the policy number or group number of the other health insurance.
67	**Principal Diagnosis (DX) Code**	• Enter the ICD-10-CM diagnosis code in the unshaded area for the principal diagnosis to the highest level of specificity available.
67A-67Q	**Other DX Codes and Place of Admission (POA) Indicator**	• Enter the ICD-10-CM diagnosis code in the unshaded area to the highest level of specificity available for each additional diagnosis. • Enter one diagnosis per block, using blocks A through J only.
69	**Admit DX Code**	• Enter the ICD-10-CM diagnosis code indicating the cause of admission or include a narrative. • Note: The admitting diagnosis is only for inpatient claims.

Block No.	Description	Guidelines
74 **74a-74e**	**Principal Procedure Code and Date Other Procedure Codes and Dates**	• Enter the ICD-10-CM procedure code for each surgical procedure and the date (MM/DD/YYYY) each was performed. Note: If you are billing for access surgery in any of these blocks and the appropriate ICD-10-CM code is not shown, the claim will be automatically denied.

Table 4: Patient Status Codes for Block 17

Code	Description
01	Routine discharge
02	Discharged to another short-term general hospital
03	Discharged to Skilled Nursing Facility (SNF)
04	Discharged to Intermediate Care Facility (ICF)
05	Discharged to another type of institution
06	Discharged to care of home health service organization
07	Left against medical advice
08	Discharged or transferred to home under care of a Home IV provider
09	Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims)
20	Expired or did not recover
30	Still client (To be used only when the client has been in the facility for 30 consecutive days and payment is based on diagnosis-related group [DRG].)
40	Expired at home (hospice use only)
41	Expired in a medical facility (hospice use only)
42	Expired - place unknown (hospice use only)
43	Discharged or transferred to a federal hospital (such as a Veterans Administration [VA] hospital)
50	Hospice-Home
51	Hospice-Medical facility
61	Discharged or transferred within this institution to a hospital-based Medicare approved swing bed
62	Discharged or transferred to an inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital
63	Discharged/transferred to a Medicare-certified long-term care hospital (LTCH)
64	Discharged or transferred to a nursing facility certified under Medicaid, but not certified under Medicare
65	Discharged or transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66	Discharged or transferred to a critical access hospital (CAH)
71	Discharged to another institution of outpatient (OP) services
72	Discharged to another institution

Medical Benefit Limitations

There are some limits to the KHC medical benefit:

- Clients can only get the KHC medical benefit for one period in their lifetime.
- Clients who lose their Medicare medical coverage for failing to pay their Medicare premiums cannot get the KHC medical benefit.
- Clients who have any other medical coverage such as private insurance, Veterans Affairs (VA) benefits, or Medicaid do not qualify for the KHC medical benefit.
- Clients who already have Medicare do not qualify for the KHC medical benefit.
- Clients who turn age 65 will lose the KHC medical benefit because KHC will presume that those clients can get Medicare based on age.
- Clients who turn age 65 during their pre-Medicare period with KHC will lose the KHC medical benefit on their birthday.
- The Medical Benefit cannot be extended past the date KHC projects the client's Medicare will start, even if his or her Medicare coverage starts after that date. (This is explained in more detail in the section titled, "Medical Benefit Start and End Dates".)
- KHC does not pay for access surgery procedure codes not listed on the KHC Access Surgery Quick Sheet.

Medical Benefit Start and End Dates

A client's KHC medical benefit coverage for dialysis starts on the date KHC received his or her completed application, if the application is approved.

The KHC medical benefit end date is calculated based on the information shown on the client's CMS Form 2728 submitted with the application. Here is how:

- KHC benefits are set up to work during the time the client does not have Medicare coverage for ESRD.
- Medicare calculates the start date for medical coverage of an ESRD client as the first day of the third month following the date shown in the field of the CMS Form 2728 labeled "Date Regular Chronic Dialysis Began."
- The KHC medical benefit will end on the day before that calculated date.

Example: If the CMS Form 2728 has 2/15/2019 as the Date Chronic Dialysis Began, the KHC medical benefit end date will be 4/30/2020.

In most cases, KHC applicants get Medicare based on ESRD. However, some clients under the age of 65 are denied Medicare coverage. In the cases when Medicare coverage based on ESRD is denied for any reason other than non-payment of Medicare Part B premiums, the KHC medical benefit end date will be the day before their Medicare coverage begins based on age. However, during that time, these clients must:

- establish their Medicare ineligibility,
- maintain their KHC eligibility, and
- remain ineligible for Medicare and Medicaid.

Example: If the client is turning 65 on 10/22, the KHC Medical Benefit end date will be 9/30. (Medicare coverage always begins on the first of the month when the change will occur.)

Some KHC clients who turn 65 may not be eligible for Medicare or for Medicaid payment of Medicare premiums. A common reason that clients do not qualify for Medicare is that they lack sufficient work quarters. These clients, however, can opt to "buy-in" to Medicare themselves by paying a premium every month. In these cases, KHC will help them pay the premiums for Medicare Parts A and B as part of the KHC Medical Benefit. This will be discussed in greater detail in Chapter 6 in the section titled, "Medicare Part A and B Premium Payment Benefit."

Special Notes About Medicare and Medicaid

The client's Medicare is directly affected by their kidney treatment status (in-center hemodialysis, home dialysis, post-kidney transplant). Therefore, it is very important that providers report all changes in treatment status to KHC immediately.

KHC clients often become eligible for Medicaid retroactively to include part of the time that they were covered by the KHC Medical Benefit. If KHC has paid claims for dates of service for which a client can receive Medicaid, KHC will ask providers for a refund of the payment.

Chapter 8: Drug Benefits

The KHC drug benefit is available to all KHC clients except those with drug coverage through a private or group health insurance plan, government health plan, including Medicaid, or other third-party plan. The KHC drug benefit helps pay for up to four prescription drugs per month, including some limited diabetic supplies listed on the KHC Drug List.

Out of state pharmacy providers may submit claims if they are contracted with Texas Medicaid or the Vendor Drug Program. An exception is that KHC can cover drug costs for clients who have drug benefits from Veterans Affairs (VA) only under certain circumstances. Call KHC to determine if your client will qualify.

KHC Drug Benefit Categories

KHC has five categories of drug benefits for eligible clients:

1. **KHC standard drug benefit** for clients with no other drug coverage: KHC is the primary payer for drugs. However, KHC will not resume the standard drug benefit for clients who lose their Medicare coverage for failing to pay their Medicare premiums.
2. **KHC standard drug benefit in coordination with Medicare Part D** for clients with drug coverage through a Medicare Part D plan: KHC is the secondary payer for drugs.
3. **KHC standard drug benefit in coordination with Medicare Part C (Medicare Advantage),** or a Medicare prescription drug plan.
4. **KHC standard drug benefit in coordination with Medicare Part B** for transplant clients without partial Medicaid coverage: KHC is the secondary payer for drugs. (Partial Medicaid refers to any Medicaid coverage that does not include transportation and full prescription benefits.)
5. KHC will pay for a maximum of four drugs per month. Clients should become familiar with their drug benefit and coordination with Medicare Parts B, Part C (Medicare Advantage), and Part D (if applicable) to determine the most cost-effective use of their benefits.

KHC Standard Drug Benefit

The standard KHC drug benefit is available to clients for up to three months from their KHC effective date, or until their enrollment in a Medicare plan with

prescription drug coverage, whichever is earlier. KHC can extend the standard drug benefit beyond the initial three months if a client who is eligible for KHC is denied Medicare coverage and submits proof of that denial.

KHC transplant clients can get the standard drug benefit after their benefit coverage with Medicare has ended and their Medicare coverage is terminated based on end-stage renal disease (ESRD).

KHC's standard drug benefit allows for:

- A maximum of four drugs per month.
- $6.00 co-pay for each KHC-covered drug.
- One-month supply for each of the drugs.
- Client pays less than the $6.00 co-pay, if the amount charged by the pharmacy is less than $6.00.

KHC Drug Benefit in Coordination with Medicare

The KHC drug benefit in coordination with Medicare is for clients who are enrolled in a Part D or Medicare Advantage plan with drug coverage. KHC must know about the client's Medicare drug coverage to coordinate benefits.

KHC's coordination with Medicare Part D provides assistance with payment for the costs of their monthly premiums for Medicare Part D and for drugs that are on both the Medicare and KHC formularies. KHC does not pay premiums for Medicare Advantage (Part C) plans. Clients can get up to a 90-day supply, if prescribed as such and Medicare pays for a 90-day supply, and:

- KHC is the secondary payer for prescription drugs that are on both the KHC and Medicare Part D plan formulary.
- KHC clients have no co-pay for those drugs, except a $6.00 copay during the deductible and "gap" periods of Medicare Part D.
- KHC payments count towards the client's annual Medicare true out-of-pocket limits.
- The KHC drug benefit helps pay for immunosuppressant drugs covered under Medicare Part B for kidney transplant clients. Along with the drug benefits that KHC clients with Medicare receive, KHC kidney transplant clients with Medicare Part B also get help paying for the costs of immunosuppressants that are on both the Medicare and KHC formularies.

Providers must notify KHC of the hospital, date and type of transplant (living, living-related or cadaveric) when a KHC client receives a kidney transplant to ensure that the client has access to allowable drugs on the KHC formulary. The client who has Medicare coverage based on ESRD prior to the date of transplant will, in most cases, have three years (36 months) of Medicare coverage after the transplant.

KHC must know about the client's Medicare drug coverage to coordinate benefits. KHC coordinates with Medicare for coverage of immunosuppressants used by kidney transplant patients.

KHC, as the secondary payer, pays the 20% co-insurance. The quantity of immunosuppressants KHC can pay for is limited to the quantity Medicare will pay for.

KHC Drug Benefit in Coordination with Medicare
(For kidney transplant clients only)

The KHC drug benefit in coordination with Medicare helps pay for the immunosuppressant drugs covered under Medicare for kidney transplant clients. The immunosuppressants that are covered by KHC must be on both the Medicare and KHC formularies.

Providers need to notify KHC of the hospital, date and type of transplant (living, living-related or cadaveric) when a KHC client receives a kidney transplant, to ensure that the client has access to allowable drugs on the KHC formulary. The client who has Medicare coverage based on ESRD prior to the date of transplant will, in most cases, have three years of Medicare coverage after the transplant.

KHC must know about the client's Medicare drug coverage in order to coordinate benefits. Providers can help KHC clients with this process calling KHC Customer Service at 1-800-222-3986 to determine the current process for notifying KHC about the client's Medicare drug coverage.

KHC Drug Benefit Limitations

These are the limits to the KHC drug benefit:

- KHC will help with no more than 4 KHC-covered drugs per month.
- See the KHC Drug List to determine what drugs are covered.
    - Search for drugs by therapeutic category (PDF)

    - Search for drugs by chemical name (PDF)
- Drug categories that are not covered by KHC include ear and eye drops, shampoos, and injectables (except insulin).
- Every prescription, whether for prescription drugs or limited diabetic supplies, counts toward the KHC monthly prescription limit of four.
- All covered drugs must have a National Drug Code (NDC) number.
- All drugs must be purchased at a participating pharmacy to use the KHC drug benefit. Pharmacies can be retail, independent and mail order. For a list of participating pharmacies, please see the Medicaid/CHIP Vendor Drug Program website.
- KHC will not provide or resume a drug benefit when a client is dis-enrolled from Medicare due to non-payment of premiums. Premiums in arrears that are owed to Medicare must be paid before KHC coverage may be resumed.

Special Note about Open Enrollment for KHC clients with Medicare Part D

KHC is deemed a State Pharmaceutical Assistance Program (SPAP) by the Centers for Medicare and Medicaid Services (CMS). KHC clients with Medicare Part D coverage are allowed to change their Medicare Part D prescription drug plan once in a calendar year, in addition to the one time they are allowed to do so during the open enrollment period.

Normally, people with Medicare Part D are only allowed to change plans during the open enrollment period.

The KHC Formulary

(Reimbursable Drug List)

The KHC Formulary is a list of drugs approved as program benefits. The list contains drugs from a variety of categories appropriate for ESRD clients that have been reviewed for medical and fiscal efficacy prior to being approved. New drugs submitted to KHC for reimbursement may be automatically added to the formulary if the drug is already on the formulary by its generic or chemical name, and its manufacturer has signed a rebate agreement with KHC. Only nephrologists or renal transplant surgeons may request revisions to the formulary. Dialysis clients, renal transplant clients and other members of the public are advised to consult a

nephrologist or renal transplant surgeon if they wish to request that a drug be added to the formulary.

KHC considers the following items when deciding to include a drug on its formulary:

- available funding through KHC appropriations;
- the cost of the drug and the cost impact to KHC;
- existence of the drug manufacturer's rebate agreement with the State of Texas;
- the similarity of the drug to other drugs on the formulary; and
- the benefit of the drug to end stage renal dialysis or renal transplant recipients.

Pharmacy Information

KHC clients must go to a participating pharmacy to use their KHC drug benefit. For a list of participating pharmacies, please see https://www.txvendordrug.com/providers/pharmacy-search on the Texas Medicaid/CHIP Vendor Drug Program website.

Appendix A: KHC Documents and Forms

This section has hyperlinks to documents you can expect to use as a provider with the Kidney Health Care program.

KHC Access Surgery Quick Sheet

Form 3035 - KHC Program Application

Form 3057 - KHC Physician Assessment

KHC Medicare Part D Update Form (PDF)

KHC Insurance Update Form (PDF)

CMS-1500 Claim Form

Note: The Centers for Medicare & Medicaid Services (CMS) is a federal agency within the U.S. Department of Health and Human Services. Many CMS program related forms are available in Portable Document Format (pdf). Hard copy forms may be available from intermediaries, carriers, state agencies, local social security offices or end stage renal disease networks that service your state.

CMS does not supply the form to providers for claim submission. Blank copies of the form may also be available through office supply stores in your geographic area. Although a copy of that form can be downloaded, copies of the form should not be downloaded for submission of claims, since your copy may not accurately replicate colors included in the form. These colors are needed to enable automated reading of information on the form.

KHC Dialysis Quick Sheet

Direct Deposit Enrollment Form

KHC Travel Form (PDF, English)

KHC Travel Form (PDF, Spanish)

KHC Client Handbook

Flier for New KHC Applicants: You just applied to KHC! E-KHC-010 in English and

¡Acaba de solicitar KHC! E-KHC-010A in Spanish

KHC Formulary by therapeutic category or Formulary by chemical name

KHC Provider Agreement (will be sent to provider by mail)

Kidney Health Care Act

Kidney Health Care Rules

Appendix B: Tables of Figures