

KIDNEY HEALTH CARE PROVIDER MANUAL



TEXAS
Health and Human
Services

May 1, 2012

41-13519 Rev. 11-2018

Table of Contents

KIDNEY HEALTH CARE PROVIDER MANUAL	1
Table of Contents	2
Introduction.....	4
Chapter 1: Overview of the Kidney Health Care Program (KHC)	5
History of Kidney Health Care	5
KHC Benefits.....	5
Client Eligibility Criteria	6
Chapter 2: Provider Enrollment	7
Interim Enrollment and Claims Filing.....	7
Enrollment of Pharmacies	8
Enrollment of Texas Medicare Prescription Drug Plans	8
Change of Ownership (CHOW).....	8
Reasons for Suspension or Termination of Enrollment	8
Chapter 3: Provider Responsibilities.....	10
Contract Requirements	10
KHC Training Opportunities	12
Chapter 4: Provider Rights.....	13
Administrative Review and Fair Hearing	13
Administrative Review Process	14
Fair Hearing Process	14
Chapter 5: Submission of Client Applications, Updates and Travel Claims..	16
Submission of Client Applications	16
Submission of Client Updates and Travel Claims	17
Travel Claim Filing Deadlines	18
Limitations to KHC Travel Benefits	18
Chapter 6: Premium Payment Assistance.....	19
Medicare Parts A and B Premium Payment.....	19
Medicare Part D Premium Payment.....	19
Low-Income Subsidy (LIS) and How It Affects KHC's Payments	20
Prescription Drug Plan (PDP) Reference Sheet	20
Chapter 7: Medical Benefits and Claims Filing.....	21
Medical Services Covered Under the Medical Benefit.....	21
Dialysis Treatments	21
Payment for dialysis treatments that exceed monthly maximum	21
Rates	22
Access Surgery Services	22

Retroactivity of access surgery benefits	22
Claim Filing and Deadlines.....	23
Access Surgery	23
Inpatient and Outpatient Dialysis Treatment	23
Resubmitting Claims.....	23
How to Complete Medical Claim Forms	24
UB-04 CMS-1450 Required Fields	26
Medical Benefit Limitations	31
Medical Benefit Start and End Dates	31
Special Notes About Medicare and Medicaid:	32
Chapter 8: Drug Benefits.....	33
KHC Drug Benefit Categories	33
KHC Standard Drug Benefit	34
KHC Drug Benefit in Coordination with Medicare Part D	34
KHC Drug Benefit in Coordination with Medicare Parts B and D (for kidney transplant clients <i>only</i>)	35
KHC Drug Benefit Limitations.....	36
Special Note about Open Enrollment for KHC clients with Medicare Part D ...	36
The KHC Formulary (also called the Reimbursable Drug List).....	36
Pharmacy Information.....	37
Appendix A: KHC Documents and Forms.....	38
Table of Figures.....	39

Introduction

Welcome to Kidney Health Care! This provider manual is designed to answer the questions you may have about what to do as a provider with our program. It is separated into chapters that identify your rights and responsibilities as a provider, the different benefits we offer our clients, and how to file your claims so that we can process them efficiently.

We recognize that there may be times when you cannot find the answer you need, so please feel free to call our help desk at 1-800-222-3986, Monday through Friday from 8 a.m. to 5 p.m. Central Time. We are here to serve you.

Thank you for enrolling in Kidney Health Care and for the care you extend to our clients!

Kidney Health Care

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Chapter 1: Overview of the Kidney Health Care Program (KHC)

The Kidney Health Care program (KHC) of the Texas Department of State Health Services (DSHS) improves access to health care by providing a source of limited benefits for eligible Texas residents with end-stage renal disease (ESRD). This goal aligns with the DSHS mission "to improve health and well-being in Texas," and shares the DSHS vision of "A Healthy Texas."

History of Kidney Health Care

In April of 1973, the [Kidney Health Care Act](#) established the Kidney Health Care Program (KHC). In passing the act, the state recognized that patients with chronic kidney disease might die for lack of personal resources required to pay for the expensive equipment and care necessary for their survival, and recognized its responsibility to allow its citizens to remain healthy without being pauperized by that care. Patients who are either uninsured or have not yet qualified for Medicare based on ESRD or other reasons are responsible for the costs for their care. Even those who qualify for Medicare based on their diagnosis of ESRD have to wait for three months before their Medicare benefits begin and will incur the costs of their care during that time. KHC exists to help people in these situations.

KHC operates under the Texas Administrative Code, [Title 25, Part 1, Chapter 61, Subchapter A](#) at the Texas Department of State Health Services (formerly the Texas Department of Health). The rights and responsibilities of KHC providers are described in the later chapters of this manual.

KHC Benefits

All KHC benefits are contingent upon funding from the state legislature. They also depend on the type of treatment provided and the client's eligibility for benefits from private insurance or other programs, including Medicare, at the time of treatment.

There are different types of KHC benefits. KHC clients may get some or all of these benefits.

- **Medical**

The KHC Medical Benefit helps clients with their medical costs for access surgery and dialysis treatments until their Medicare starts.

- **Drugs**

The KHC Drug Benefit helps clients with their out-of-pocket costs for ESRD-related drugs, including the immunosuppressive drugs for kidney transplant clients.

- **Premium Payment Assistance**

KHC can help clients pay their Medicare premiums for Parts A, B and D.

- **Travel**

The KHC Travel Benefit helps clients pay for the costs associated with travel to and from their dialysis treatments or ESRD-related medical visits. KHC enrolled dialysis providers submit most of the travel claims on behalf of KHC clients.

Client Eligibility Criteria

KHC clients must meet all of the following criteria:

- Have a diagnosis of ESRD certified by a physician.
- Be receiving regular dialysis treatments or have received a kidney transplant.
- Be a Texas resident.
- Have a gross annual income of less than \$60,000.
- Must apply for Medicare based on ESRD

KHC clients cannot:

- Have full Medicaid (drugs, transportation, and medical benefits).
- Be a ward of the state or be incarcerated in a city, county, state or federal jail or prison.

Only approved dialysis facilities or hospitals can submit applications for KHC benefits, by using the web-based Automated System for Kidney Information Tracking (ASKITWeb), or by mailing the original paper application to the KHC office in Austin. For a facility to be approved to submit client applications, it must be enrolled as a KHC provider and certified by the Centers for Medicare and Medicaid Services.

Chapter 2: Provider Enrollment

The outpatient dialysis facility is the most common KHC provider, but KHC also enrolls physicians, physician groups, Certified Registered Nurse Anesthetists (CRNAs), hospitals, Ambulatory Surgical Centers (ASCs), pharmacies, and stand-alone Medicare Prescription Drug Plans in Texas.

KHC providers must be located within Texas. However, providers who are within 50 miles of the Texas state border but within the United States are considered to be in-state providers if they are a Texas Medicaid provider. Military hospitals also can enroll as providers with KHC but are not eligible for KHC payments.

To enroll in KHC, a provider must complete the enrollment application and:

- Be in good standing with KHC, the State of Texas, and the Texas Medicaid Program;
- Be a current Texas Medicaid provider;
- Have Medicare approval when required;

Out-of-state outpatient dialysis facilities, hospitals, ASCs, physicians and CRNAs that enroll in KHC must meet the same requirements. However, their licenses or certifications must be from the state in which they are providing services and they must be in good standing in their respective state.

Interim Enrollment and Claims Filing

Providers who want to enroll in KHC have six months to complete their enrollment packet and submit it along with all the supporting documentation. During this interim enrollment period, the provider can:

- submit client applications, travel reports and client updates (hospitals and dialysis facilities *only*), and
- file medical claims for services rendered to KHC clients. (These claims will be denied but can be resubmitted after the provider's enrollment is complete. All filing deadlines and client eligibility will be applied. See "Claim Filing" Section for details.)

If the provider receives full approval and becomes enrolled during the interim period, KHC will be able to pay those medical claims that are a benefit of the program if the following two conditions are met:

1. the provider submitted the original claim within regular filing deadlines, and
2. the provider resubmits those claims after receiving full approval within 60 days from the date on the agreement approval letter, but not later than 180 days from the date of service. (See "Claim Filing" section for deadlines.)

If the provider fails to complete the enrollment process or meet the provider eligibility requirements (e.g. become Medicare certified or enrolled in Medicaid) during that six-month period, any claims filed during that period will no longer be eligible for payment. Additionally, those providers will have to start the entire enrollment process again and commence a new interim enrollment period.

Enrollment of Pharmacies

Pharmacies, including mail order pharmacies, become KHC providers by entering into an agreement to participate in KHC through the Texas Health and Human Services Commission (HHSC) Vendor Drug Program (VDP) or its designated contractor. More information is located on the [HHSC website](#).

Enrollment of Texas Medicare Prescription Drug Plans

KHC enrolls stand-alone Texas Medicare Prescription Drug Plans (PDP) to coordinate premium payment benefits for KHC clients. Texas PDPs that enroll in KHC receive a separate provider manual. Contact KHC at 1-800-222-3986 for more information.

Change of Ownership (CHOW)

Any KHC-enrolled provider that changes ownership must notify KHC immediately and submit a new enrollment packet, including provider agreement, for that new ownership. KHC will also need to know if the new owner will assume liability for outstanding balances in effect or incurred by the previous owner. KHC will assign a new provider number upon completion of enrollment.

Once the Medicare ESRD certification letter for the new dialysis facility or hospital owner is received and the old provider's account has been cleared, KHC will terminate the old provider account, initiate a new provider account, and transfer clients to the new provider's account. This will enable the dialysis facility to submit client updates and new client applications as well as submit travel claims on behalf of their KHC clients. Social workers will not have ASKIT Web access until the provider completes the packet and is enrolled.

KHC will notify the old owner by letter if there is a problem with clearing the provider's account. The old owner's account must be cleared before the new owner can progress with the enrollment process.

Contact KHC at 1-800-222-3986 or kidneyet@dshs.state.tx.us to start or learn more about the process if your organization is planning or has undergone a change of ownership.

Reasons for Suspension or Termination of Enrollment

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

- loss of approval or exclusion from participation in the Medicare program;
- exclusion from participation in the Medicaid program;
- providing false or misleading information;
- a material breach of any contract or agreement with KHC;
- filing false or fraudulent information or claims;
- failure to submit a payable claim to KHC during a minimum period of 12 consecutive months; or
- failure to maintain participation criteria as outlined in the contract.

A provider may appeal a termination or suspension through the administrative review and fair hearing process described later.

Chapter 3: Provider Responsibilities

KHC providers must follow the [KHC Program Rules](#) and the responsibilities detailed in the KHC provider agreement. KHC includes two provider agreements with the enrollment packet it sends to providers. Providers who elect to enroll in KHC must sign and return both copies as part of the enrollment process. Providers will receive one of the agreements back once KHC enrollment is completed. Note: The provider agreement is a binding, legal document.

Contract Requirements

Providers must:

- Be aware that any false claims, statements, documents, or concealment of material fact, may be prosecuted under applicable state laws.
- Be aware that KHC will withhold payment of claims and apply any reimbursed amount to recoup any overpayments to the provider for medical claims.
- Not discriminate against an individual on the basis that the person is a KHC client.
- Identify KHC clients who demonstrate Limited English Proficiency (LEP) to ensure they are provided with the necessary language assistance and have equal access to KHC services.
- Promptly report to KHC temporary closures of their facility.
- Promptly report to KHC changes in any of the following:
 - ownership
 - name
 - address
 - acting agents (e.g., social workers)
 - status of Medicare, Medicaid, DSHS licensing, or other required license and certifications
- Providers must file all claims within filing deadlines.
 - See "Medical Benefits and Claims Filing" chapter for details on filing medical claims.
 - See "Submission of Client Applications and Travel Claims" chapter for details on filing travel claims.

Many times, the enrolled dialysis and hospital providers use social workers to act as agents on its behalf in complying with their KHC responsibilities and in conducting some of the business with KHC clients. Those providers must inform and ensure that these agents understand and follow KHC rules and the terms of the KHC Provider Agreement. The list that follows includes some of the more common roles that social workers fill.

- Screen patients for KHC eligibility and submit completed KHC application forms for client benefits through the mail or ASKITWeb, if approved for use.

- Provide an explanation of KHC benefits and limitations to applicants, using the KHC flier for new applicants: [You just applied to KHC!](#) E-KHC-010 in English and [¡Acaba de solicitar KHC!](#) E-KHC-010A in Spanish. The flier can be downloaded using the links or ordered from the DSHS Publication Warehouse online at <http://webds.dshs.state.tx.us/mamd/litcat>.
- Screen and assist KHC applicants when applying for Medicare, the Low-Income Subsidy through Medicare, Medicaid, or any other funding to help pay for their health care.
- Retain records related to client applications and travel claims for a minimum of five years unless DSHS has raised questions about the documents.
 - Retain a **copy** of original paper applications sent to KHC.
 - Retain the **original** paper document that corresponds to all applications submitted online.
 - Ensure that they have access to documents that support travel claims submitted to KHC.
- Provide, upon request, free copies of and access to all records pertaining to the services for which claims and applications are submitted to KHC.
- Verify and submit outpatient facility hemodialysis travel reports for eligible clients as described in Chapter 5, "Submission of Client Applications, Updates and Travel Claims."
- Immediately notify or submit information to KHC if a client:
 - expires.
 - regains kidney function or voluntarily stops treatment for ESRD.
 - becomes eligible for drug, transportation, and medical benefits under the Medicaid Program.
 - receives health-care benefits from another entity, public or private.
 - experiences a change in income or financial status that will affect the client's eligibility.
 - becomes a ward of the state.
 - becomes incarcerated in a city, county, state or federal jail or prison.
- Inform KHC immediately (prior to filing medical and travel claims) about changes to the client's:
 - permanent home or mailing address.
 - type of treatment (e.g., hemodialysis, peritoneal dialysis, transplant).
 - insurance coverage (including changes in their Medicare Part D plan).
 - treatment facility.
 - round-trip mileage to treatment location.

- mode of transportation to the dialysis facility, for example by ambulance.

KHC Training Opportunities

KHC encourages all providers to complete our online training course, KHC 101. This free, self-paced course is a comprehensive look at KHC and details client eligibility, how to submit travel claims, the three types of benefits, as well as client and provider responsibilities. The course offers continuing education credit for social workers and is a prerequisite for training in how to use KHC's online application and travel claims system called ASKITWeb. ASKITWeb use can decrease the amount of time required for submitting and processing KHC applications and claims. Providers who complete ASKITWeb training will be expected to:

- Complete and submit a unique Computer Usage Agreement for each user before accessing ASKITWeb.
- Use ASKITWeb to submit all applications, claims, and client information updates.

Chapter 4: Provider Rights

All dialysis providers have a right to:

- Know the status of applications they submit to KHC on behalf of their patients. The Notice of Eligibility (NOE) they will receive will contain either a specific date on which eligibility for KHC benefits will begin or an explanation of why KHC denied the application.
- Expect KHC to make a determination regarding the eligibility for KHC 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 KHC 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 fully enrolled in KHC have a right to:

- An Administrative Review in the event KHC:
 - denies a claim.
 - suspends the provider's approval to participate in KHC.
 - terminates the provider's approval to participate in KHC.
- 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 KHC upholds the original decision, the provider can request a Fair Hearing.

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

- denial of KHC eligibility.
- denial of benefit payment.

Adverse decisions that a provider can receive include:

- denial of claim payment.
- termination of KHC 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 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 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 KHC action will become final.

Administrative Review Process

The Administrative Review process is as follows:

- KHC 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** calendar days from the date of the notice to request an Administrative Review.
- KHC accepts a request for an Administrative Review in writing or through email from a client, social worker or any agent acting on behalf of the affected party. Providers and clients can also call KHC and a customer service representative will assist them in requesting the administrative review.
- KHC conducts a comprehensive review of the request, using all available documentation.
- KHC sends the affected party an Administrative Review response letter with the decision to uphold, partially overturn or completely overturn KHC's prior decision. The Administrative Review response letter will include:
 - the action KHC intends to take, and
 - an explanation of the reasons for the action.
- If KHC 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, and
 - the address where 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 KHC 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 KHC's decisions and include any documents or other proof that help support those reasons.
- KHC will forward the fair hearing request to the DSHS Office of General Counsel.

- The Office of General Counsel is then responsible for scheduling 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

(Dialysis Facilities and Hospitals Only)

Dialysis facilities and hospitals enrolled in KHC can submit the [KHC client application](#) for benefits, client updates, and client travel claims.

- Facilities that have access to ASKITWeb **must** submit client applications and forms online.
- Facilities without ASKITWeb access must submit **paper applications, updates,** and travel claims.
- Facilities that have initiated enrollment and are pending approval will be able to submit client updates and client travel claims on paper.

Submission of Client Applications

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

The [Kidney Health Care Application for Benefits](#) and [instructions](#) are 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 filled in, and the four pieces of documentation in the list below. All documents must be in English or accompanied by an accurate English translation.

- End-Stage Renal Disease Medical Evidence Report (CMS-2728 Form)
- Social Security Document
- Residency Document
- Income Verification Document

The application with all the supporting documents attached, must be signed by the applicant and notarized. The provider must submit the complete application to KHC via US mail or electronically through ASKITWeb.

Complete applications must be submitted to avoid delays in application processing. KHC will deny applications that remain incomplete after two weeks. KHC will be available to assist providers in any way 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 they submit online and copies of supporting documentation.

Submission of Client Updates and Travel Claims

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

- Submit any updates to client information before submitting travel claims for that month.
 - Updates entered in ASKITWeb will be processed in real time, but 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 that have access to ASKITWeb must submit updates and travel claims online.
- Facilities must submit travel claims by the 15th of the month following the month when travel occurred.
- KHC will deny 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.
- KHC will not allow facilities to submit subsequent travel claims until it receives and processes the claims for the current month.

The way the facilities identify KHC clients and submit travel claims on their behalf depends on the facility's access to ASKITWeb.

- Facilities that have access to ASKITWeb generate an electronic version of the monthly travel list by clicking the appropriate button in ASKIT every month.
- Facilities that do not have ASKITWeb access will receive the monthly travel list (called the "Monthly Dialysis Travel Verification Form") and an Update Status report form in the mail from KHC at the beginning of the month following the month for which travel is being reported.
 - Only clients eligible for travel benefits on the first day of the reported month being treated at that facility will be on the travel list.
 - The RTM on record for the client is included on the list. Please review mileage and immediately report any discrepancies.

Travel Claim Filing Deadlines

KHC must receive travel claims within 95 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:

- Travel is subject to inner-city and city-to-city mileage caps. This means that the final round-trip mileage may be less than what the client reports or what is calculated using Google Maps Driving Directions.
- The benefit is subject to a maximum of \$200 per month.
- Travel claims must be submitted according to filing deadlines. (See "Filing Deadlines" above for details.)
- The benefit depends on the type of treatment the client receives for their kidney disease (in-center hemodialysis, home peritoneal dialysis or kidney transplant).
- 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 in order to avoid interruption in payment of the client's travel claims.
- Home peritoneal and transplant clients file their own travel claims.
- KHC cannot process incomplete or incorrectly submitted travel claims.

For more information on the KHC Application, Travel Benefit and Travel Claim filing, consult Kidney Health Care 101

Chapter 6: Premium Payment Assistance

KHC has a benefit 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
- be paying for both Medicare A and B themselves using the "buy-in" option
- choose the "direct bill" method for payment (not have their premiums auto-deducted from their Social Security payment)
- not be eligible for Medicaid
- submit their Medicare invoices to KHC.

KHC can also pay for the Medicare Part B premiums for clients who have received a kidney transplant.

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 will not help with any other type of Medicare Part D plan (such as Medicare Advantage plans or plans that are not in Texas).
 - 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 and How It Affects KHC's Payments."
- Clients pay any amount above what KHC pays.
- Clients **must** choose the "direct bill" option for their monthly payment. This lets the Part D plan 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. 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 extra help, KHC will pay no more than \$25 in premium assistance.

Clients can call the Social Security Administration at 1-800-772-1213 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. The current fact sheet is located on [KHC's Medicare Part D News and Updates web page](#). 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 the low-income subsidy (LIS), by percentage
- the KHC applied amount
- the client's responsibility based on his or her 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 to learn how to use KHC'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 nurse anesthetist).

Dialysis Treatments

KHC coverage for inpatient and outpatient maintenance dialysis treatments depends on the type of treatment (in-center hemodialysis, home dialysis, 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. In order for KHC to consider payment for the additional treatment, providers must follow this procedure:

- Submit a claim for the additional treatment.
- KHC will deny the claim.

- Submit 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.)
- Include 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

Code	Procedure
5498	Peritoneal Dialysis
90935	Hemodialysis, one eval.
90937	Hemodialysis, repeated eval.
90945	Dialysis, one eval.
90947	Dialysis, repeated eval.
90989	Dialysis training, complete
90993	Dialysis training, incomplete
90997	Hemoperfusion
90999	Dialysis procedure

Rates

KHC pays flat rates for dialysis treatment and training. Please call the KHC Customer Service at 1-800-222-3986 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 [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 End-Stage Renal Disease (ESRD) is approved for Medicare or Kidney Health Care (KHC), a KHC client's medical benefits for access surgery are retroactive and can be paid if the surgery happens:

- 180 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 1-800-222-3986 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 Explanation of Benefits (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.

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 days from the last day of the month in which services were provided; or
- 60 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:

- 60 days from the date on the agreement approval letter, and
- not later than 180 days from the date of service.

Inpatient and Outpatient Dialysis Treatment

Providers must submit all outpatient claims on the CMS-1500 paper form, or online through ASKITWeb (outpatient dialysis facilities *only*). KHC must receive the claims:

- within 95 days from the last day of the month in which services were provided, **or**
- within 60 days from the date on KHC's Notice of Eligibility (NOE) for newly approved clients, **or**
- within 60 days of the date on the approval letter for newly approved dialysis facilities, but not later than 180 days from the date of service.

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 (if submitting on paper) or through ASKITWeb.

- Include no additional charges for service

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

How to Complete Medical Claim Forms

KHC 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-9-CM codes for procedures. The required fields for claims submission are shown in the sections that follow.

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	<ul style="list-style-type: none"> • 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-9-CM diagnosis codes to the highest level of specificity available. ACS providers are not required to enter diagnosis codes.

Block No.	Description	Guidelines
24	(Various)	General notes for Blocks 24a through 24j: <ul style="list-style-type: none"> • 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. Include only one service month per claim form.
24b	Place of service	Select the appropriate POS code for each service.
24d	Fully describe procedures, medical services, or supplies furnished for each date given	Enter the appropriate procedure codes and modifier for all services billed.
24e	Diagnosis pointer	Enter the line item reference (1, 2, 3, or 4) of each diagnosis code identified in Block 21 for each procedure. Indicate the primary diagnosis code only. Do not enter more than one diagnosis code reference per procedure. This can result in denial of the service.
24f	Charges	Indicate the usual and customary charges for each service listed. Charges must not be higher than fees charged to private-pay clients.
24g	Days or units	If multiple services are performed on the same day, enter the number of services performed (such as the quantity billed).
25	Federal Tax ID #	Enter the Tax ID number of the billing provider shown in Block 33.
26	Patient's account number	Optional Enter any alphanumeric characters (up to 15) in this block.
28	Total charge	Enter the total charges. For multi-page claims enter "continue" on initial and subsequent claim forms. Indicate the total of all charges on the last claim. <i>Note: Indicate the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form.</i>
29	Amount paid	Enter any amount paid by an insurance company or other sources known at the time of submission of the claim. Identify the source of each payment and date in Block 11. If the client makes a payment, the reason for the payment must be indicated in Block 11.

Block No.	Description	Guidelines
30	Balance due	If appropriate, subtract Block 29 from Block 28 and enter the balance.
31	Signature of physician or supplier	The physician, supplier or an authorized representative must sign and date the claim.
32	Service facility location information	Enter the name, address, and ZIP+4 code of the facility where the service was provided.
33	Billing provider info & PH #	Enter the billing provider's name, street, city, state, ZIP+4 code, telephone number, and 6-digit KHC provider number.
33A	NPI	Enter the NPI of the billing provider.

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 provider number of provider rendering services.
3a	Patient control number	Optional Any alphanumeric character (limit 16).

Block No.	Description	Guidelines
4	Type of bill (TOB)	<p>Enter a TOB code.</p> <p>First Digit—Type of Facility: 1 Hospital 3 Home health agency 7 Clinic (rural health clinic [RHC], federally qualified health center [FQHC]) 8 Special facility</p> <p>Second Digit—Bill Classification (except clinics and special facilities): 1 Inpatient (including Medicare Part A) 2 Inpatient (Medicare Part B only) 3 Outpatient 4 Other (for hospital-referenced diagnostic services, for example, laboratories and X-rays)</p> <p>Third Digit—Frequency: 0 Nonpayment/zero claim 1 Admit through discharge 2 Interim-first claim 3 Interim-continuing claim 4 Interim-last claim 5 Late charges-only claim 6 Adjustment of prior claim 7 Replacement of prior claim</p>
5	Federal Tax ID number	Enter the federal tax ID number of the billing provider shown in block number 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).
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.

Block No.	Description	Guidelines
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 special source of admission code in Block 15.) 5 Trauma center
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. List ancillaries in ascending order.

Block No.	Description	Guidelines
44	HCPCS/rates	<p>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.</p> <p>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.</p>
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	Serv. units	<p>Provide units of service, if applicable.</p> <p>For inpatient services, enter the number of days for each accommodation listed. If applicable, enter the number of pints of blood.</p> <p>When billing for observation room services, the units indicated in this block should always represent hours spent in observation.</p>
47	Total charges	Enter the total charges for each service provided.
47 (line 23)	Totals	Enter the total charges for the entire claim. <i>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.</i>
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.
61	Insured group name	Enter the name and address of the other health insurance.

Block No.	Description	Guidelines
62	Insurance group number	Enter the policy number or group number of the other health insurance.
67	Principal diagnosis (DX) code	Enter the ICD-9-CM diagnosis code in the unshaded area for the principal diagnosis to the highest level of specificity available.
67A-67Q	Other DX codes and POA indicator	Enter the ICD-9-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-9-CM diagnosis code indicating the cause of admission, or include a narrative. <i>Note: The admitting diagnosis is only for inpatient claims.</i>
74 74a-74e	Principal procedure code and date Other procedure codes and dates	Enter the ICD-9-CM procedure code for each surgical procedure and the date (MM/DD/YYYY) each was performed. <i>Note: If you are billing for access surgery in any of these blocks and the appropriate ICD-9-CM code is not shown in one of these blocks, the claim will be automatically denied.</i>

Table 4: Patient Status Codes for Block 17

Code	Description
01	Routine discharge
02	Discharged to another short-term general hospital
03	Discharged to 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

Code	Description
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, VA benefits, or Medicaid cannot get the KHC medical benefit.
- Clients who already have Medicare cannot get the KHC medical benefit.
- Clients will lose the KHC medical benefit when they turn age 65 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 65th 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 below in the section titled, "Medical Benefit Start and End Dates".)
- KHC does not pay for access surgery procedure codes not listed on the [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's 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 2/15/2009 as the Date Chronic Dialysis Began, the KHC medical benefit end date will be 4/30/2009.

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 below 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, or other third-party plans such as Medicare Advantage Plans. The KHC Drug Benefit helps pay for up to four prescription drugs, vitamins, over-the-counter (OTC) products, and limited diabetic supplies listed on the KHC Drug List, per month.

Exception: KHC can cover drug costs for clients who have drug benefits from the Veterans Administration (VA) only under certain circumstances. Call KHC to determine if your client will qualify.

KHC Drug Benefit Categories

KHC has three categories of drug benefits for eligible clients depending on their other Medicare and partial Medicaid coverage:

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 stand-alone Texas Medicare Part D plan: KHC is the secondary payer for drugs.
3. **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 prescriptions.)

Regardless of the benefit a particular client has, 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 and D (if applicable) in order to determine the most cost-effective use of their benefits. The chart on the next page summarizes KHC drug benefits.

Table 5: KHC Drug Benefit Coordination

Type of Drug Insurance	Type of KHC Client	KHC Drug Benefit Client Will Receive	Will KHC Coordinate with Medicare Part D?
None	Any KHC client	Standard	n/a
Private	Any KHC client	None	n/a
Medicare Advantage Plan	Any KHC client	None	n/a
Medicare Part D stand-alone plan outside of Texas	Any KHC client	None	n/a
Medicare Part D Texas stand-alone plan	Any KHC client	Drug Benefit in Coordination with Medicare Part D	Yes
Medicare Part D Texas stand-alone plan PLUS Medicare Part B for immunosuppressants	Transplant clients only	Drug Benefit in Coordination with Medicare Part D PLUS Coverage for Immunosuppressants	Yes

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 Medicare Part D enrollment date, 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.

KHC transplant clients can get the standard drug benefit after they have completed their benefit coverage with Medicare and have had their Medicare Parts A, B, & D coverage terminated based on kidney condition.

KHC’s Standard Drug Benefit allows for a:

- A maximum of four drugs per month.
- \$6.00 co-pay for each KHC-covered drug.
 - Client pays less than the \$6.00 co-pay, if the amount claimed by the pharmacy is less than \$6.00.
- One-month supply for each of the drugs.
- The drugs Valcyte and Ganciclovir have additional conditions. Call KHC for more information.

KHC Drug Benefit in Coordination with Medicare Part D

The KHC Drug Benefit in Coordination with Medicare Part D is for clients who are enrolled in a Texas Stand-Alone Part D Drug plan **only**. KHC must know about the client’s Medicare Part D drug coverage in order to coordinate benefits. Providers can help KHC clients with this process by referring to the Medicare

Part D page of the [KHC website](#) or by calling the KHC Help Desk at 1-800-222-3986 to determine the current process for notifying KHC about the client's Part D plan.

KHC's coordination with Medicare Part D provides assistance with payment for the costs of their monthly premiums for Medicare Part D, drugs that are on both the Medicare **and** KHC formularies, and certain vitamins and over-the-counter (OTC) drugs that are on the KHC formulary only. (All of these drugs are included in the 4-drug per month maximum.)

- Clients can get up to a 90-day supply, if prescribed as such.
- KHC is the **secondary** payer for prescription drugs that are on both the KHC **and** Medicare Part D plan's formularies.
- KHC clients have no co-pay for those drugs, even during the deductible and "gap" periods of Medicare Part D.
- KHC payments count towards the client's yearly Medicare true out-of-pocket limits.
- KHC is the **primary** payer for one-month supplies of certain prescription vitamins and OTC drugs that are on the KHC formulary **only**.

KHC Drug Benefit in Coordination with Medicare Parts B and D (for kidney transplant clients *only*)

The KHC Drug Benefit in coordination with Medicare Parts **B and D** helps pay for the immunosuppressant drugs covered under Medicare Part B for kidney **transplant** clients. Along with the drug benefits the KHC clients with Medicare Part D receive, KHC's 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 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 Part D drug coverage in order to coordinate benefits. Providers can help KHC clients with this process by referring to the Medicare Part D page of the [KHC website](#) or by calling KHC Customer Service at 1-800-222-3986 to determine the current process for notifying KHC about the client's Part D plan.

- KHC coordinates with Medicare Part D as for other KHC clients.
- KHC also coordinates with Medicare Part B for coverage of immunosuppressants used by transplant patients.
 - KHC, as the **secondary** payer, pays the 20% co-insurance.
 - The quantity of immunosuppressants KHC can pay for is limited to whatever quantity Medicare can pay for.
- Clients can use the KHC Standard Drug Benefit for certain prescription vitamins and OTC drugs that are on the KHC drug list **only**. These

supplements are not usually included on a Medicare plan's covered drug lists. In this instance, KHC is the primary payer. Clients can get a one-month supply for a co-pay of \$6.

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.
 - 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 vitamins, limited diabetic supplies, or OTC products on the KHC formulary, counts toward the KHC monthly prescription limit of four.
- All covered drugs must have a [National Drug Code \(NDC\)](#) number. This includes vitamins, OTC products, and limited diabetic supplies.
- Diabetic supplies must be prescribed by a licensed physician.
- 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 [KHC Pharmacy Search](#) page of the Texas Medicaid/CHIP Vendor Drug Program website.
- KHC will **not** provide or resume a drug benefit when a client is disenrolled from Medicare due to non-payment of premiums.
- KHC will **not** coordinate drug benefits for clients who:
 - Have drug coverage through a Medicare Advantage Plan
 - Are enrolled in Medicare Part D plans that are based outside of Texas
 - Have Medicare Part D and any other insurance with drug coverage
 - Have drug coverage through any other insurance

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

KHC is a State Pharmaceutical Assistance Program (SPAP) within Medicare. Therefore, 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 (also called the Reimbursable Drug List)

The KHC Formulary is a list of drugs approved as program benefits. The list contains drugs from a wide 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. Therefore, 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 the [KHC Pharmacy Search](#) page of 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.

[2012 KHC Prescription Drug Plan](#) (PDP) Premium Payment Fact Sheet

[Access Surgery Quick Sheet](#)

[Client Application for Benefits](#) and [Application Instructions](#)

[Client Status Update Form](#)

[CMS-1500 Claim Form](#)

[Dialysis Rates](#)

[Direct Deposit Enrollment Form](#)

[Fax Cover for KHC Medicare Rx Update](#)

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 Client Handbook](#)

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](#)

[Travel Claim Form](#) for Home Dialysis and Kidney Transplant Clients (KHC-3) in English and [Formulario para reclamar viajes](#) De clientes que hacen diálisis en casa o recibieron un trasplante de riñón (KHC-3A) in Spanish

UB-04 CMS-1450 Claim Form (a Medicare/Medicaid form)

Table of Figures

Table 1: Procedure Codes Covered by KHC.....	22
Table 2: CMS-1500 Required Fields	24
Table 3: CMS-1450 Required Fields	26
Table 4: Patient Status Codes for Block 17	30
Table 5: KHC Drug Benefit Coordination.....	34