REIMBURSEMENT POLICY

Hemodialysis/Peritoneal Dialysis

Active

Policy Number: General Coding – 039
Policy Title: Hemodialysis/Peritoneal Dialysis
Section: General Coding
Effective Date: 03/13/17

Description

This policy is designed to address medical guidelines that are appropriate for the majority of individuals with a particular disease, illness, or condition. Each person's unique clinical circumstances may warrant individual consideration, based on review of applicable medical records.

Definitions

Dialysis is a process by which waste products are removed from the body by diffusion from one fluid compartment to another across a semi-permeable membrane. The two types of dialysis commonly in use are hemodialysis and peritoneal dialysis.

Policy Statement

Single evaluation

- A standard "uncomplicated" dialysis session. The physician visits/evaluates the patient but because of no complications, does not perform any other service for the patient during that dialysis session.
  - 90935, 90945, G0491, G0492

Repeated evaluations

- Evaluations with or without substantial revision of dialysis prescription that are intended to represent a "complicated" dialysis session. The physician may visit the patient several times during a session and may also adjust the dialysis prescription.
  - 90937, 90947, G0491, G0492

Consultations and medical visits

- When provided on the same day as out-patient dialysis procedures by the same provider or his or her associate are not eligible for separate reimbursement. Payment for such care is included in the allowance for the dialysis procedure with physician evaluation. If the consultations and medical care are for a non-renal condition as documented in the patient's medical records, medical necessity must be determined through a medical review. Modifier 25 may be reported with

medical care (e.g. visits, consults) to identify it as significant and separately identifiable from the other service(s) provided on the same day. When modifier 25 is reported, the patient's records must clearly document that separately identifiable medical care was rendered unrelated to the dialysis procedure or renal failure which cannot be rendered during the dialysis session.

- 90935, 90937, 90940, 90945, 90947, 96160, 96161, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99288, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99386, 99401, 99402, 99403, 99404, 99411, 99412, 99429, 99485, 99486, 99499, G0380, G0381, G0382, G0383, G0384, G0491, G0492

- When the severity of the renal condition requires the patient to be hospitalized, inpatient consultations and medical visits provided on the same day as dialysis procedures by the same provider or his or her associate are not eligible for separate reimbursement. Payment for such care is included in the allowance for the dialysis procedure with physician evaluation. If the consultations and medical care are for a non-renal condition as documented in the patient's medical records, medical necessity must be determined through a medical review. Modifier 25 may be reported with medical care (e.g. visits, consults) to identify itas significant and separately identifiable from the other service(s) provided on the same day. When modifier 25 is reported, the patient's records must clearly document that separately identifiable medical care unrelated to the dialysis procedure or renal failure which cannot be rendered during the dialysis session was performed.
  - 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99251, 99252, 99253, 99254, 99255, 90935, 90937, 90940, 90945, 90947

- Claims for an unscheduled or emergency dialysis treatment for an End Stage Renal Disease (ESRD) patient in a hospital outpatient department that is not an ESRD facility should be processed using code G0257.

- Continuous Ambulatory Peritoneal Dialysis (CAPD) is a method of dialysis performed by the patient. If a hospitalized CAPD patient requires assistance in this self-dialysis technique, it can be provided by hospital staff. Consequently, charges billed by a physician for CAPD sessions regardless of the place of service should be denied. Inpatient medical care rendered on a fee-for-service basis is eligible.

The following services performed in conjunction with dialysis are not covered:

- Self-dialysis sessions (no codes)
- Staff-assisted dialysis sessions (no codes)
- Monthly maintenance care
- Home visit for hemodialysis
- Dialysis training

- Connecting tube administration set, change by physician (no code)
- Catheter site inspection by physician (no code)
- Examination by physician for peritonitis (no code)
- Physician review of CAPD apparatus and/or technique (no code)
- Hemodialysis access flow study to determine blood flow in grafts and arteriovenous fistulae by an indicator dilution method
    - 90940, 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, 90966, 90967, 90968, 90969, 90970, 90983, 90989, 99512

Place of Service: Outpatient
Hemodialysis/Peritoneal Dialysis is typically an outpatient procedure which is only eligible for coverage as an inpatient procedure in special circumstances, including, but not limited to, the presence of a co-morbid condition that would require monitoring in a more controlled environment such as the inpatient setting.

Documentation Submission

Documentation/ must identify and describe the procedures performed. If a denial is appealed, this documentation must be submitted with the appeal.

Coverage

Coverage is subject to the specific terms of the member's benefit plan.

The following applies to all claim submissions.

All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in Provider Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be reimbursed according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated, if appropriate, using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only, and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement.

CPT / HCPCS Modifier:	25
ICD Diagnosis:	N/A
ICD Procedure:	N/A
HCPCS:	90935, 90937, 90940, 90945, 90947, 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, 90966, 90967, 90968, 90969, 90970, 90983, 90989, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, 99255, 99281, 99282, 99283, 99284, 99285, 99288, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99401, 99402, 99403, 99404, 99411, 99412, 99420, 99429, 99485, 99486, 99499, 99512, G0257, G0380, G0381, G0382, G0383, G0384, G0491, G0492
Revenue Code(s):	0800, 0801, 0802, 0803, 0804, 0809, 0820, 0821, 0822, 0823, 0824, 0825, 0826, 0829, 0830, 0831, 0832, 0833, 0834, 0835, 0839, 0840, 0841, 0842, 0843, 0844, 0845, 0849, 0850, 0851, 0852, 0853, 0854, 0855, 0859, 0880, 0881, 0882, 0889
Deleted Codes:	N/A

Policy History

Initial Committee Approval Date:	January 18, 2017
Code Update:	N/A
Policy Review Date:	February 4, 2019
Cross Reference:	N/A