Medical Necessity Guidelines: Out-of-Network Outpatient Dialysis at the In-Network Level of Benefits

Effective: October 21, 2020

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	**Yes ☒ No ☐**

Applies to:

COMMERCIAL Products

☒ Tufts Health Plan Commercial products; Fax: 617.972.9409

☒ Tufts Health Freedom Plan products; Fax: 617.972.9409

- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

TUFTS HEALTH PUBLIC PLANS Products

☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax:888.415.9055

☐ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055

☐ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404

☐ Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 857.304.6304

*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

SENIOR Products

- Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the Tufts Health Plan SCO Prior Authorization List
- Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

OVERVIEW

All Tufts Health Plan Members whose benefit plans do not include out-of-network coverage (e.g., HMO, EPO) are required to receive treatment from in-network providers except in emergencies or the rare instances in which services are not available from an in-network provider. Members whose benefit plans includes coverage for out-of-network services with non-contracted providers (e.g., POS, PPO) have the option of receiving services from out-of-network providers at the unauthorized or out-of-network level of benefits (subject to their applicable deductible, co-payment and/or coinsurance). For Members of all plans, to receive services from an out-of-network provider at the in-network level of benefits, prior authorization for such services must be obtained from Tufts Health Plan. Without such prior authorization, HMO/EPO Members will not be covered for out-of-network services and PPO/POS Members will be covered for such services only at the out-of-network/unauthorized level of benefits.

These guidelines provide the prior authorization standard for determining whether it is medically necessary for the Member to receive outpatient dialysis services (including hemodialysis or peritoneal dialysis) from an out-of-network provider.

A directory of in-network dialysis providers can be located here.

Requests for prior authorization should be submitted on the following form: Out-of-Network Dialysis Authorization Form.

Prior authorization is not required for the following services: 1) outpatient dialysis (including hemodialysis or peritoneal dialysis) provided by an in-network provider, or 2) short-term outpatient dialysis from an out-of-network provider while the Member is outside the service area of the Member's plan.

CLINICAL COVERAGE CRITERIA

Tufts Health Plan may authorize coverage of dialysis services provided by an out-of-network provider at the in-network level of benefits when the following criteria are met:

1. Outpatient dialysis services are not available within Tufts Health Plan's geographic access standard, which is 30 miles from the Member's primary residence

OR

2. Outpatient dialysis services received in the Member's primary residence are not available from an in-network provider

CODES

The following CPT code(s) require prior authorization for coverage from an out-of-network provider at in-network level of benefits.

Table 1: CPT Codes Applicable

CPT Code	Description
90935	Hemodialysis procedure with single physician evaluation
90937	Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription
90945	Dialysis procedure other than hemodialysis (e.g. peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), with single physician evaluation
90947	Dialysis procedure other than hemodialysis (e.g. peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), requiring repeated evaluation(s) with or without substantial revision of dialysis prescription
90951	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month
90952	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face physician visits per month
90953	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month
90954	End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month
90955	End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face physician visits per month
90956	End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month
90957	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month
90958	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face physician visits per month

CPT Code	Description
90959	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month
90960	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face physician visits per month
90961	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 2-3 face-to-face physician visits per month
90962	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face physician visit per month
90963	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90964	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90965	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90966	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older
90967	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age
90968	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 2-11 years of age
90969	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 12-19 years of age
90970	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older
90989	Dialysis training, patient, including helper where applicable, any mode, completed course
90993	Dialysis training, patient, including helper where applicable, any mode, course not completed, per training session
90997	Hemoperfusion (e.g., with activated charcoal or resin)
90999	Unlisted dialysis procedure, inpatient or outpatient
99512	Home visit for dialysis

REFERENCES

None

APPROVAL HISTORY

September 14, 2016: Reviewed by the Integrated Medical Policy Advisory Committee (IMPAC).

Subsequent endorsement date(s) and changes made:

- October 24, 2016: Reviewed by the Integrated Medical Policy Advisory Committee for an effective date of January 1, 2017. Final language reviewed
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
- August 9, 2017: Reviewed by IMPAC, renewed without changes
- October 10, 2018: Reviewed by IMPAC, renewed without changes
- October, 2018: Template and disclaimer updated
- October 16, 2019: Reviewed by IMPAC, renewed without changes
- June 24, 2020: Fax number for Unify updated
- October 21, 2020: Reviewed by IMPAC, renewed without changes
- December 4, 2020: Fax number for Unify updated

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.