Dialysis Payment Policy

Applies to the following Tufts Health Plan products:

☒ Tufts Health Plan Commercial (including Tufts Health Freedom Plan)
☒ Tufts Medicare Preferred HMO (a Medicare Advantage product)
☒ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)

The following payment policy applies to Tufts Health Plan contracting outpatient dialysis providers who perform outpatient dialysis services.

In addition to the specific information contained in this policy, providers must adhere to the information outlined in the Professional Services and Facilities Payment Policy.

Note: Audit and disclaimer information is located at the end of this document.

POLICY
Tufts Health Plan covers peritoneal and hemodialysis services, as described below.

DEFINITION
Dialysis is the process of cleansing the blood by passing it through a special machine. There are two types of dialysis: hemodialysis and peritoneal dialysis.

Hemodialysis is a medical procedure that uses a dialysis machine to filter waste products from the blood and restore normal constituents to it.

Peritoneal dialysis is a technique that uses the patient’s own body tissues inside of the abdominal cavity to act as a filter.

GENERAL BENEFIT INFORMATION
Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider website or by contacting Commercial Provider Services or Senior Products Provider Relations.

Note: There is no member responsibility for covered services for Tufts Health Plan SCO members.

Commercial
Tufts Health Plan care managers support Commercial members with chronic kidney conditions, including the management of ESRD. For information on chronic kidney disease and end-stage renal disease (ESRD), refer to the Chronic Kidney Condition Program. For more information about this program, call the Priority Care line at 888.766.9818, ext. 53532.

AUTHORIZATION REQUIREMENTS
Prior authorization is not required for Tufts Medicare Preferred HMO and Tufts Health Plan SCO members. Members must use in-network providers for dialysis services within the service area.

Commercial Products
HMO/EPO members must use in-network providers for outpatient dialysis services within the service area, except in rare instances in which services are not available from an in-network provider. In such circumstances, coverage of outpatient dialysis services from an out-of-network provider are subject to prior authorization and will be determined by an authorized reviewer at Tufts Health Plan.

Note: A referral signed by an IPA reviewer is not sufficient. POS/PPO members must receive prior authorization to receive outpatient dialysis services from out-of-network providers at the in-network/authorized level of benefits. For more information on prior authorization for out-of-network services, refer to the Medical Necessity Guidelines for Out-of-Network Outpatient Dialysis at the In-Network Level of Benefits.

1 Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLinkSM when Tufts Health Plan is the primary administrator.
For information on kidney transplants for Commercial members, refer to the [Solid Organ Transplant: Kidney Medical Necessity Guidelines](#).

**BILLING INSTRUCTIONS**

- Submit any attachment(s) identifying each date of service, procedure code, procedure description, and dosage of medication if applicable.
- Ancillary providers may only bill the procedure code(s) in accordance with their Provider Agreement.
- Submit multiple pages of a single claim and number the pages at the bottom of each claim form. If the claim form pages are not numbered, each claim form will be entered as a separate claim.
- Submit monthly charges once per month. Submitting more than one claim for the same monthly charges may result in a duplicate denial.

Tufts Medicare Preferred HMO and Tufts Health Plan SCO members diagnosed with ESRD follow Medicare guidelines. Refer to [CMS](#) for additional information.

**Coordination of Benefits for ESRD**

Members diagnosed with ESRD must apply for Medicare coverage when enrolled on a Tufts Health Plan Commercial product under an employer group plan. Tufts Health Plan requires members diagnosed with ESRD to apply for Medicare coverage (parts A and B) under the ESRD entitlement reason during the first 33 months of treatment. After the member's first dialysis treatment, a three month waiting period will begin before Medicare coverage is available and an additional 30 month coordination period exists in which Tufts Health Plan is primary and Medicare is secondary. The 30 month coordination period starts on the date the member is eligible to receive Medicare benefits. On the 31st month, Medicare becomes the primary payer and Tufts Health Plan becomes secondary. If the member applies for Medicare and does not qualify, Tufts Health Plan will continue as primary payer.

If the member chooses not to enroll with Medicare Parts A and B but is eligible to participate in the Medicare program, Tufts Health Plan will limit coverage to 20 percent of healthcare costs and the member will be responsible for 80 percent after the 33rd month from the first date of dialysis.

The Medicare three-month waiting period can be shortened or eliminated if the member:

- takes part in a home dialysis program
- is admitted to a Medicare–approved hospital for services related to kidney transplant
- is scheduled for a kidney transplant prior to the end of the coordination period

Medicare coverage due to ESRD ends 12 months after dialysis treatments end; however, termination of dialysis is unlikely unless the person receives a kidney transplant. For members who undergo a kidney transplant, Medicare coverage would end 36 months after a successful transplant. An unsuccessful transplant usually requires a resumption of dialysis treatment.

**COMPENSATION/REIMBURSEMENT INFORMATION**

Tufts Health Plan does not pay a differential rate for the first 120 days of dialysis.

Outpatient dialysis is compensated on a bundled, per treatment basis. The four severity factor adjustments used by Original Medicare (i.e., patient-level, onset of dialysis, outliers and facility-level) are not applied to the reimbursement rate.

Tufts Health Plan compensates for dialysis services when reported with place of service home (12), outpatient (22) or an ESRD treatment facility (65).

**Commercial Only**

**Hemodialysis Frequency**

Tufts Health Plan does not compensate for hemodialysis more than three times in a six-day period when billed with an office, home, temporary lodging, outpatient hospital, or ESRD treatment facility place of service. Refer to the CMS [Internet-Only Manual](#) for more information.

**Evaluation and Management Services**

Tufts Health Plan compensates only for one E&M service on the same date of service by facility provider. Refer to the CMS [Outpatient Prospective Payment System](#) for additional information.

**ESRD Facility - Prospective Payment System**

Tufts Health Plan does not separately compensate for any drug included in ESRD consolidated billing when billed with place of service 65. Refer to CMS for more information.
ADDITIONAL RESOURCES

Coordination of Benefits Policy

DOCUMENT HISTORY

- June 2018: Template updates
- January 2017: Template updates
- November 2016: Added language regarding authorization procedures for out of network services
- September 2015: Template conversion, template updates
- April 2015: Added Tufts Medicare Preferred HMO and Tufts Health Plan SCO; template updates
- December 2014: Removed peritoneal dialysis from dialysis frequency policy, added Revenue Codes 0681-0684, 0689, 1000-1002 accepted when submitted electronically without a corresponding CPT and/or HCPCS procedure code, template updates
- May 2014: Policy reviewed; template updates; added hemodialysis, peritoneal dialysis and ESRD facility policies effective for dates of service on or after July 1, 2014.
- November 2013: Template updates
- September 2013: Template conversion
- April 2012: Template updates
- March 2012: Updated CareLink disclaimer language
- October 2011: Template updates, no content changes
- August 2010: Added home dialysis information to reimbursement section
- July 2009: Added definition, health programs & coordination of benefits information
- February 2008: Revised general benefit information with self-service channels information

AUDIT AND DISCLAIMER INFORMATION

Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that an office/facility did not comply with this payment policy, Tufts Health Plan will expect the office/facility to refund all payments related to noncompliance. For more information about Tufts Health Plan’s audit policies, refer to the Provider website.

This policy provides information on Tufts Health Plan claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the Tufts Health Plan products, as identified in the checkboxes on the first page, and to CareLink℠ for providers in Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna’s provider agreements with respect to CareLink members. This policy does not apply to the Private Health Care Systems (PHCS) network (also known as Multiplan). Tufts Health Plan reserves the right to amend a payment policy at its discretion.