

Dialysis Payment Policy

Applies to the following Tufts Health Plan products:

- Tufts Health Plan Commercial (including Tufts Health Freedom Plan)¹
- Tufts Medicare Preferred HMO (a Medicare Advantage product)²
- Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)²

Applies to the following Tufts Health Public Plans products:

- Tufts Health Direct (a Massachusetts Qualified Health Plan (QHP) (a commercial product)
- Tufts Health Together (a MassHealth MCO Plan and Accountable Care Partnership Plans)
- Tufts Health RITogether (a Rhode Island Medicaid Plan)
- Tufts Health Unify (OneCare Plan; 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 medically necessary peritoneal and hemodialysis services³, in accordance with the member's benefits.

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 [Provider Services](#).

Note: There is no member responsibility for covered services for Tufts Health Plan SCO, Tufts Health Unify, Tufts Health Together or Tufts Health RITogether members.

Commercial Products

Tufts Health Plan care managers support Commercial members with chronic kidney conditions, including the management of ESRD. For additional information on the Complex Care Management program, refer to the Utilization Management Guidelines chapter of the [Commercial Provider Manual](#).

REFERRAL/AUTHORIZATION/NOTIFICATION REQUIREMENTS

Certain procedures, items and/or services may require referral and/or prior authorization. While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you must confirm that prior authorization has been obtained.

Commercial Products

Prior authorization is required for members to receive services from an out-of-network provider at the in-network 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.

² Tufts Medicare Preferred and Tufts Health Plan SCO are collectively referred to in this payment policy as Senior Products.

³ Dialysis services include, but are not limited to, labs, drugs, tubing change, adapter change and training related to hemodialysis and peritoneal dialysis (intermittent, continuous cycling and continuous ambulatory)

Senior Products and Tufts Health Public Plans

Prior authorization is **not** required for dialysis services for Senior Products or Tufts Health Public Plans.

For more information refer to the [Referral, Authorization and Notification Policy](#).

BILLING INSTRUCTIONS

Unless otherwise stated, Tufts Health Plan accepts all industry standard codes. Refer to current industry standard resources for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules. For more information, refer to the [Professional Services and Facilities Payment Policy](#).

Use of noncontracting labs may have the unintended consequence of subjecting the member to unnecessary services not ordered by the treating provider or other unreasonable financial exposure. In such circumstances, Tufts Health Plan may hold the ordering provider accountable for any inappropriate behavior on the part of the nonparticipating lab that has been selected.

COMPENSATION/REIMBURSEMENT INFORMATION

Providers are compensated according to the applicable network contracted rates and fee schedules. For additional information, refer to the [Professional Services and Facilities Payment Policy](#).

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

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

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.

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.

Commercial Products Only

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](#)
[Solid Organ Transplant: Kidney Medical Necessity Guidelines](#)

DOCUMENT HISTORY

- June 2020: Reviewed by committee; added Tufts Health Public Plans and removed outdated billing instructions
- 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

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 CareLinkSM 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.