Reimbursement Policy

End-Stage Renal Disease - Dialysis

Policy Number: SCO 4.95
Version Number: 4
Version Effective Date: 09/01/2021

Product Applicability

☐ **All Plan+ Products**

Well Sense Health Plan
☐ Well Sense Health Plan

Boston Medical Center HealthNet Plan
☐ MassHealth MCO
☐ MassHealth ACO
☐ Qualified Health Plans/ConnectorCare/Employer Choice Direct
☒ Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan reimburses covered services based on the provider's contractual rates with the Plan and the terms of reimbursement identified within this policy.

Prior-Authorization

Please refer to the Plan's Prior Authorization Requirements Matrix at www.bmchp.org.

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Provider Reimbursement

The Plan reimburses all outpatient maintenance renal dialysis treatments furnished to end stage renal disease (ESRD) beneficiaries in accordance with the Centers for Medicare and Medicaid Services (CMS). The Plan reimburses providers through the ESRD Prospective Payment System (PPS). for rendering dialysis services in an ESRD facility or a member's home. The ESRD PPS provides a single payment that covers all the resources used in providing an outpatient dialysis treatment, including those services provided by other suppliers and providers. If another provider renders a renal dialysis service to an ESRD beneficiary, the ESRD facility should reimburse the provider for the services provided.

The following ESRD related services are included in the PPS payment:

- Supplies and equipment used to administer dialysis in the ESRD facility or at an enrollee's home
- Drugs
- Biologicals
- Laboratory tests
- Training
- Support services

Consolidated Billing

The ESRD PPS includes consolidated billing requirements for limited Part B services included in the ESRD facility's bundled payment. CMS periodically updates the lists of items and services that are subject to Part B consolidated billing and are therefore no longer separately payable when provided to ESRD beneficiaries by providers other than ESRD facilities. Providers should reference the CMS *Items and Services Subject to ESRD PPS Consolidated Billing* list.

ESRD PPS Adjustments

Adjustments to the PPS payment may be applicable. Providers should reference the CMS ESRD PPS webpage for detailed descriptions for the following:

Patient Level Case mix Adjustments

- Age
- Body surface area
- Low body mass index
- Member Co-morbidity categories
- Onset of Dialysis

Facility Level Adjustments:

- Geographic wage index adjustment
- Low Volume Facility
- Rural payment adjustment
- Training Add-On

Other Adjustments:

- High Cost Outlier

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- Transitional Drug Add-On Payments
- Transitional Add-on Payment Adjustment for New and Innovative Equipment and Supplies

Separately Reimbursed Services/Supplies

The following are not considered ESRD PPS services and are reimbursed according to the Medicare provisions for each type of service:

- Blood products/blood processing
- Preventive vaccinations
- Telehealth services
- Services reported with modifier AY (Item or service furnished to an ESRD patient that is not for the treatment of ESRD)

Service Limitations

- No payment is made if the facility sets up for a dialysis treatment but the treatment is not started.

Applicable Coding and Billing Guidelines

Applicable coding is listed below, subject to codes being active on the date of service. Because the American Medical Association (AMA), the Centers for Medicare & Medicaid Services (CMS), and the U.S. Department of Health and Human Services may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes may not be all inclusive. These codes are not intended to be used for coverage determinations.

Timeliness of Billing

ESRD services should be reported monthly in accordance with Medicare. Line item detail billing is required for ESRD claims.

Split Claim Billing

All related services provided on the same date of service must be reported on one claim. Subsequent related claims for the same date of service received after the initial claim will be denied. The initial claim must be resubmitted as a replacement claim.

Taxonomy

The Plan requires providers to submit the Medicare approved taxonomy in field locator 81 for paper claims, or the electronic equivalent. Claims submitted without the taxonomy code will be denied.

Reporting the Onset of Dialysis

Providers must report the onset of dialysis date with the occurrence code 48.

Policy History

Original Approval Date	Original Effective Date	Policy Owner	Approved by
11/04/2015	01/01/2016	Payment Policy	SCO Product Subgroup

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
06/19/2019	Annual Review, new template	07/01/2019	Payment Policy Committee
04/20/2021	Annual Review, no changes	05/15/2021	Payment Policy Committee
08/17/2021	Reorganized to reference CMS website for details of PPS adjustments. Added section for taxonomy reporting and Onset of Dialysis date. Added section for Consolidated billing	09/01/2021	Payment Policy Committee

Other Applicable Policies

- General Billing and Coding Guidelines, SCO 4.31
- General Clinical Editing and Payment Accuracy Review Guidelines, SCO 4.108

References

- Centers for Medicare and Medicaid Services, Medicare Benefit Policy Manual 100-02, Chapter 11 End Stage Renal Disease
- Centers for Medicare and Medicaid Services, Medicare Benefit Policy Manual 100-02, Chapter 15 Covered Medical and Other Health Services
- Centers for Medicare and Medicaid Services, Medicare Claims Processing Manual 100-04, Chapter 8 Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims
- Centers for Medicare and Medicaid Services, ESRD PPS CONSOLIDATED BILLING LIST
- Centers for Medicare and Medicaid Services, ESRD PPS Comorbidity Categories and Diagnosis Codes

Disclaimer Information

This Policy provides information about the Plan's reimbursement/claims adjudication processing guidelines. The use of this Policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization

management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement. Member cost-sharing (deductibles, coinsurance and copayments) may apply – depending on the member's benefit plan. Unless otherwise specified in writing, reimbursement will be made at the lesser of billed charges or the contractual rate of payment. Plan policies may be amended from time to time, at Plan's discretion. Plan policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization guidelines (including NCQA). The Plan reserves the right to conduct Provider audits to ensure compliance with this Policy. If an audit determines that the Provider did not comply with this Policy, the Plan will expect the Provider to refund all payments related to non-compliance. For more information about the Plan's audit policies, refer to the Provider Manual.

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