Reimbursement Policy

**End-Stage Renal Disease - Dialysis**

**Policy Number:** SCO 4.95  
**Version Number:** 1  
**Version Effective Date:** 01/01/2016

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<tr>
<th>Product Applicability</th>
<th>All Plan* Products</th>
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<tbody>
<tr>
<td><strong>Well Sense Health Plan</strong></td>
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<td>□ New Hampshire Medicaid</td>
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<td>□ NH Health Protection Program</td>
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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.
End-Stage Renal Disease (ESRD) Reimbursement

The Plan reimburses dialysis treatments when they are provided to ESRD enrollees in various settings: hospital outpatient facility, independent dialysis facility, or the enrollee’s home. The Plan will provide a single base rate payment per dialysis treatment to ESRD facilities that will cover all the resources used in providing an outpatient dialysis treatment, including those services provided by other suppliers and providers. The following ESRD related services are included in the base rate 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

In addition to the base rate payment, the Plan will provide further reimbursement for the following:

- Onset of renal dialysis
- Case-mix adjusters
- Training
- Outliers

**Onset of Renal Dialysis**

An adjustment will be made during the first 4 months of dialysis. When the onset of dialysis adjustment is provided, the claim is not entitled to a comorbid adjustment or a training adjustment.

**Case-Mix Adjustment**

In addition to the base rate payment, there is added reimbursement for specific patient case-mix adjusters. These case-mix adjusters include the following:

- Age
- Body surface area
- Low body mass index
- Three adult chronic comorbid categories:
  - Hereditary hemolytic and sickle cell anemia
  - Monoclonal gammopathy (in the absence of multiple myeloma)
  - Myelodysplastic syndrome
- Three adult acute comorbid categories:
  - Bacterial Pneumonia
  - Gastrointestinal Bleeding

* Plan refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.
Pericarditis

Training
Facilities that are certified to furnish training services will receive additional reimbursement to account for an hour of nursing time for each training treatment that is furnished. The training add-on applies to both peritoneal dialysis (PD) and hemodialysis (HD) training treatments.

Outliers
Certain ESRD services which meet the outlier threshold, will qualify for additional reimbursement. ESRD services used for an outlier determination and which are eligible for an outlier adjustment are the following items and services that were separately payable by Medicare prior to January 1, 2011:

- ESRD related drugs and biologicals
- ESRD related laboratory tests
- Medical/surgical supplies used to administer ESRD related drugs

For the most current list of outlier services, go to the Centers for Medicare and Medicaid Services website: http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Outlier_Services.html

Separately Reimbursed Services/Supplies
Blood products, blood processing, preventive services and vaccinations, telehealth services, and services reported with modifier AY (Item or service furnished to an ESRD patient that is not for the treatment of ESRD) will be reimbursed separately from the dialysis base rate payment.

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.

Policy History

<table>
<thead>
<tr>
<th>Original Approval Date</th>
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<th>Policy Owner</th>
<th>Approved by</th>
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<tbody>
<tr>
<td>11/04/2015</td>
<td>01/01/2016</td>
<td>Payment Policy</td>
<td>SCO Product Subgroup</td>
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Next Review Date
2017

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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

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.