HOME DIALYSIS

Policy Number: 2016M0044A  Effective Date: February 1, 2016

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INSTRUCTIONS:

“Medical Policy assists in administering UCare benefits when making coverage determinations for members under our health benefit plans. When deciding coverage, all reviewers must first identify enrollee eligibility, federal and state legislation or regulatory guidance regarding benefit mandates, and the member specific Evidence of Coverage (EOC) document must be referenced prior to using the medical policies. In the event of a conflict, the enrollee’s specific benefit document and federal and state legislation and regulatory guidance supersede this Medical Policy. In the absence of benefit mandates or regulatory guidance that govern the service, procedure or treatment, or when the member’s EOC document is silent or not specific, medical policies help to clarify which healthcare services may or may not be covered. This Medical Policy is provided for informational purposes and does not constitute medical advice. In addition to medical policies, UCare also uses tools developed by third parties, such as the InterQual Guidelines®, to assist us in administering health benefits. The InterQual Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice. Other Policies and Coverage Determination Guidelines may also apply. UCare reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary and to provide benefits otherwise excluded by medical policies when necessitated by operational considerations.”
POLICY DESCRIPTION:

This policy describes the use of home dialysis, a treatment for end-stage renal disease (ESRD). Dialysis is an artificial process that takes over some of the work normally performed by healthy kidneys. The main functions of dialysis include clearing wastes from the blood, restoring the balance of certain electrolytes in the blood, and eliminating extra fluid from the body.

Dialysis is most frequently used for patients who have kidney failure, but may also be used to quickly remove drugs or poisons in acute situations. This use can be life-saving.

There are two types of dialysis:

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

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

Dialysis is most often done in a special dialysis center. Under certain conditions a patient can be trained through an approved program to perform home dialysis.

COVERAGE RATIONALE / CLINICAL CONSIDERATIONS:

HOME DIALYSIS

A. **Hemodialysis:**

Hemodialysis equipment for in-home use is safe and effective and considered **MEDICALLY NECESSARY** for patients with end stage renal disease (ESRD) as a therapeutic option, when all of the following conditions are met:

1. Patient has stable end stage renal disease ESRD.
2. Patient is capable of completing a home dialysis training program and adhering to a prescribed treatment regimen.
3. Patient has a reliable caregiver and arrangements with a backup, facility-based dialysis center.
4. Patient is under a plan of care prepared and periodically reviewed by a physician and receiving periodic monitoring by skilled nursing visits.

Wearable home hemodialysis units are considered **EXPERIMENTAL AND INVESTIGATIONAL**.

B. **Peritoneal Dialysis:**

Continuous ambulatory peritoneal dialysis (CAPD) or continuous cycling peritoneal dialysis (CCPD) is considered **MEDICALLY NECESSARY** when prescribed by a physician for a person with end-stage renal disease.

Clinical Considerations:

Potential Harms: Patients performing home hemodialysis (HHD) can experience the same intradialytic and interdialytic symptoms as patients undergoing in-center HD such as nausea, headache, muscle cramps, hypotension, and lethargy; however, in most studies, the symptoms occurred less frequently and were not
as severe compared with in-center HD.

**Complications:**

- Peritonitis, 2%
- Surgery to correct vascular access problems, 5% to 10%
- Hepatitis B infection, 3%
- Jaundice, 5%
- Pericarditis, 6%
- Marital problems, 4%
- Spousal psychiatric problems, 6%
- Intradialytic hypotension, 6%
- Infection and myocardial abscess causing death, 3%
- Gastrointestinal bleeding, 10%
- Subdural hematoma, 3%
- Uterine bleeding, 10%
- Vascular access failure, 0.05 events per patient-year
- Catheter loss, 50%

Other reported complications were stenosis or clots of arteriovenous fistulae or grafts and catheter extrusion, infection, or disconnection.

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**BACKGROUND:**

Chronic kidney disease is a progressive condition, which is defined as kidney damage persisting for ≥ 3 months demonstrated by abnormalities in blood or urine markers or on renal imaging and/or a glomerular filtration rate (GFR) < 60 mL/min/1.73 m2 for ≥ 3 months. Kidney failure is defined as either a GFR of < 15 mL/min/1.73 m2 or as the need for renal replacement therapy, e.g., dialysis or renal transplantation. Some causes of kidney failure are diabetes, hypertension, glomerulonephritis, cystic kidney disease, nephrototoxic agents, and infection. End-stage renal disease (ESRD) is manifested by signs and symptoms of uremia and the need for chronic dialysis or transplantation. Treatment of ESRD involves the management of uremia, maintenance of nutritional status, optimization of hemoglobin and serum phosphate, and prevention of comorbidities through dialysis or transplantation.

Dialysis is the process of removing solutes that accumulate as a result of diminished renal function. This process removes waste products from the body by diffusion from one fluid compartment to another across a semi-permeable membrane. Dialysis is normally indicated in the management of patients with end stage renal disease (ESRD). Dialysis may also be required because of temporary kidney failure due to sudden trauma, or to quickly remove drugs or poisons in acute situations.

There are two modalities of dialysis: Hemodialysis and Peritoneal dialysis.

1. **Hemodialysis (HD):** The most common type of renal replacement therapy, removes urea, other waste products and excess fluid directly from the vascular system as blood passes through a dialyzer. Conventional HD is performed 3 times per week for 3 to 5 hours at a hospital or dialysis center. The intermittency of this therapy, which results in wide fluctuations in fluid and electrolyte balances, increases the risk of complications such as dehydration or overhydration. While HD prolongs life expectancy, it is limited by a high annual mortality rate (20%).
In an effort to improve outcomes, the efficacy and safety of HD administered more frequently during the day or overnight have been evaluated. It has been hypothesized that, compared with conventional HD, high-intensity HD provides more effective removal of urea and better control of uremic symptoms, fluid balance, blood pressure, and other complications of renal failure, along with improvements in quality of life (QOL) and survival. High-intensity HD can be performed in a patient’s home with coordination of care by a nephrologist, dialysis nurse, dialysis technician, dietician, social worker, and others. During home hemodialysis (HHD), the patient self-dialyzes several times per week at home on a more intensive schedule than conventional, intermittent in-center HD. HHD is intended to reduce morbidity and mortality associated with conventional HD by shortening the interdialytic interval, which decreases fluctuations in fluid, solute, and electrolyte balance, and more closely mimics physiological kidney function. For HHD, the patient is trained to self-dialyze during the daytime or overnight using units equipped with dialyzer modules, a reusable apparatus, and a water treatment appliance. The patient and caregivers are responsible for maintaining the dialysis equipment. Vascular access is provided by arteriovenous fistulas, arteriovenous grafts, or central vein catheters. The patient’s home must have sufficient space to accommodate the dialysis module, which consists of the dialyzer, arterial line with a blood pump, and a venous line with an air trap, and other equipment. There must be an adequate number of electrical outlets and a source of purified water adjacent to the equipment, as well as backup resources. Most centers employ remote monitoring systems of the HD sessions through a telephone or internet connection. A healthcare professional is available for consultation, and the patient is monitored at regular intervals in a physician’s office or outpatient center. Daily HD is performed 5 to 7 times per week for 1 to 4 hours during the day. Nocturnal HD is performed overnight 5 to 7 times per week for 6 to 10 hours.

Aside from the cost-saving benefits, the main advantage of home hemodialysis is the independence the patient develops. Instead of traveling to a dialysis unit two or three times a week, patients dialyze at home. Some home hemodialysis patients dialyze at night, an option that may not be available in all dialysis units. Continued employment is, therefore, common among home dialysis patients. The demands of home hemodialysis care tend to make patients more knowledgeable about their disease and the treatment required. Some believe this increased knowledge makes home hemodialysis patients more responsive to the suggestions of doctors and nurses about their care. In some of the rural areas of the country, home hemodialysis may eliminate many hours of travel to and from dialysis units. This improves the patient’s chances to continue to work.

2. Peritoneal Dialysis: A type of dialysis where the filtering takes place within the member’s abdominal cavity without the blood leaving the body. There are 3 types of Peritoneal Dialysis: (1) Continuous Ambulatory Peritoneal Dialysis (CAPD), (2) Continuous Cycling Peritoneal Dialysis (CCPD), and (3) Intermittent Peritoneal Dialysis (IPD).
   a. Intermittent Peritoneal Dialysis - Waste products pass from the patient’s body through the peritoneal membrane into the peritoneal (abdominal) cavity where the dialysate is introduced and removed periodically. The general frequency of peritoneal dialysis is three (3) sessions per week.
   b. Continuous Ambulatory Peritoneal Dialysis (CAPD) - A variation of peritoneal dialysis that uses the patient’s peritoneal membrane as a dialyzer. CAPD was developed for home dialysis patients. The frequency of CAPD fluid exchanges is three (3) to five (5) times daily.
   c. Continuous Cycler-Assisted Peritoneal dialysis (CCPD) - A variation of peritoneal dialysis which requires a machine called a cycler to fill and drain the abdomen, usually during sleep. CCPD is also
sometimes called Automated Peritoneal Dialysis (APD).

**Short-Run or Short-Daily Dialysis:** Hemodialysis in which the length of each session is shortened, but the frequency is increased to 5 or 6 times weekly. Due to insufficient clinical evidence to support medical efficacy, short-run or short-daily dialysis is considered not MEDICALLY NECESSARY.

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### REGULATORY STATUS:

1. **U.S. FOOD AND DRUG ADMINISTRATION (FDA):**
   
   Hemodialysis machines used for Sustained low-efficiency dialysis (SLED) and continuous renal replacement therapies (CRRT) are regulated via the FDA 510(k) as Class II (moderate-risk) devices. Although the complete list of hemodialysis machines is too extensive for inclusion here, the following HD systems, which were used in the studies reviewed in this report, have received 510(k) approval from the FDA (approval date):
   
   - Fresenius Polysulfone Dialyzers (Fresenius USA, Inc., Walnut Creek, CA) (December 12, 2003) (FDA, 2004a).
   - Cobe Centrysystem® 3 Plus™ Dialysis Control Unit (Gambro Healthcare, Lakewood, CO) (September 26, 1997) (FDA, 2004b).
   - Fresenius 2008H Dialyzer (Fresenius USA Inc.) approved July 3, 1997 (K961465).
   - Toray Model 2.0 Dialyzer (Toray Industries (America) Inc.), originally approved February 27, 1989 (K883407) as the Toray Filtryzer BK Series.

2. **CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS):**
   
   Hemodialysis (HD) performed in a hospital, satellite center, or at home, is approved for coverage by Medicare for the treatment of patients with ESRD. The usual pattern of frequency for hemodialysis is 3 sessions per week. Additional composite rate payments may be made when they are medically justified. Medicare coverage includes dialysis equipment if the devices are required because the patient has ESRD, have been determined to be medically necessary, are appropriate for home use, and are of the type prescribed by renal specialists at approved home dialysis training centers. Coverage includes home dialysis support services for monitoring, emergency visits; record keeping, ESRD-related laboratory testing, testing and appropriate treatment of water, and monitoring the function of dialysis equipment.


   **The following are examples of coverage for dialysis and related services:**

   a. Acute Dialysis - Dialysis given to patients who are not ESRD patients, but who require dialysis because of temporary kidney failure due to a sudden trauma; examples include but not limited to traffic accident or ingestion of certain drugs.
   
   b. CAPD (Continuous Ambulatory Peritoneal Dialysis) home dialysis support services are covered as
General home dialysis services:
1) Start-up durable supplies (whether or not they are part of a start-up kit) such as weight scales, blood pressure apparatus (sphygmomanometer), IV stand, dialysate heaters and reasonable costs of a reclining chair to facilitate delivery of dialysis.
2) Consumable and disposable supplies such as dialysate, tubing and gauze pads
3) Members changing from another form of home dialysis to CAPD may have rental or lease purchase of home durable equipment up to three months after completing CAPD training course.

Full range of home general dialysis services, plus:
1) Changing the connecting tube (administration set)
2) Supervision of the member while performing CAPD and assuring that it is done correctly; reviewing for the member, any aspects of the technique he/she has forgotten or informing the member of modification in apparatus or technique
3) Documenting whether the member has or has had peritonitis that requires physician intervention or hospitalization
4) Inspection of the catheter site

Supplemental Dialysis During CAPD Training
It may be necessary to supplement the patient’s dialysis during CAPD training with intermittent peritoneal dialysis because the patient has not yet mastered the CAPD technique. Generally, no more than three supplemental intermittent peritoneal dialysis sessions are required during the course of CAPD training, and these may be covered routinely. If more than three sessions are billed during training, the claims must be documented for medical necessity. Under certain circumstances, the form of supplemental dialysis may be hemodialysis.

Equipment and Water Testing
Dialysis machine, water purification and water testing systems are not covered for members on CAPD.

Peridex CAPD Filter Set
Peridex CAPD Filters are not covered. See the NCD for Peridex CAPD Filter Set (230.13).

Notes: All services must be done in home or at a Medicare Certified Dialysis Center. Medicare pays for one month’s emergency reserve supply for Method II home dialysis patients, once in a patient’s lifetime for each dialysis modality the patient receives. Refer to the Medicare Claims Processing Manual Chapter 8 Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims 90.3 - Amount of Payment by the DMERC. Rev. 3311, 08-06-15. Available at: http://www.cms.gov/manuals/downloads/clm104c08.pdf. Accessed January 4, 2016.

Notes: Routine dialysis services may be covered when the member is temporarily absent from the service area for a period of 6 months or less. See the Medicare Benefit Policy Manual Chapter 11 § 50.8 Coverage of In Facility Dialysis Sessions Furnished to Home Patients Who Are Traveling. Available at: http://www.cms.hhs.gov/manuals/Downloads/bp102c11.pdf. Accessed January 5, 2016.

d. Laboratory tests essential to monitor the progress of chronic renal dialysis patients are covered; See NCD for Laboratory Tests – CRD Patients (190.10) (Note: Any laboratory test in excess of frequency defined under “routine laboratory tests” or any test that is not listed above is covered only if there is documentation of medical necessity.)


f. Ambulance transportation to or from dialysis facility is covered only when an ambulance level of transportation is medically necessary and other means of transportation are contraindicated or when the member is an inpatient in a skilled nursing facility (SNF) that cannot provide the services for the member. See the Medicare Benefit Policy Manual Chapter 10 § 10.3. Available at: http://www.cms.hhs.gov/manuals/Downloads/bp102c10.pdf. Accessed January 4, 2016. Also refer to the Coverage Summary for Ambulance Services.

g. Water purification and softening systems used in conjunction with Home Dialysis are covered when criteria are met. See the National Coverage Determination (NCD) for Water Purification and Softening Systems Used in Conjunction with HOME DIALYSIS (230.7) for coverage criteria.

h. Medical Nutritional Therapy (MNT) is covered when criteria are met; see the NCD for Medical Nutrition Therapy (180.1) for coverage criteria.

Notes:
1) MNT services are not covered for members receiving maintenance dialysis.
2) A member cannot receive MNT if they have received initial Diabetic Self-Management Training (DSMT) within the last 12 months unless:
   o The need for a reassessment and additional therapy has been documented by the referring physician as a result of a change in diagnosis or medical condition; or
   o The beneficiary receiving DSMT is subsequently diagnosed with renal disease.

i. Intravenous levocarnitine for those ESRD patients who have been on dialysis for a minimum of three (3) months is covered. Patients must have documented carnitine deficiency along with signs and symptoms of:
   1) Erythropoietin-resistant anemia, or
   2) Hypotension on hemodialysis that interferes with delivery of the intended dialysis

Notes: Continued use of levocarnitine will not be covered if improvement has not been demonstrated within 6 months of initiation of treatment. All other indications for levocarnitine are non-covered in the ESRD population. For more specific criteria, See the NCD for Levocarnitine for...


l. Ultrafiltration, hyperperfusion and hyperfiltration procedures are covered only when criteria are met. See the NCD for Ultrafiltration, Hemoperfusion and Hemofiltration (110.15). Also see the NCD for Ultrafiltration Monitor (230.14).

3. MINNESOTA DEPARTMENT OF HUMAN SERVICES (DHS):


   DHS follows Medicare guidelines for coverage. For dually eligible Medicare patients, refer to the coverage policy and billing requirements from Medicare.

   Eligible Providers: The following providers may enroll as ESRD providers with Minnesota Health Care Programs (MHCP):

   - Medicare approved ESRD facilities in hospitals
   - Renal transplant centers
   - Renal dialysis facilities and centers
   - Outpatient hospitals
   - Self-dialysis units
   - Special purpose renal dialysis facilities
   - Medical supply providers approved by DHS to provide ESRD services. DHS will approve only those medical suppliers who have provided home dialysis equipment and supplies to Medicare beneficiaries in the past 12 months.

   Eligible Recipients: All renal dialysis recipients must apply for Medicare benefits as soon as dialysis begins. Refer recipients as soon as possible to the Social Security Administration (SSA) to apply for Medicare (For recipients, age 18 or under, a Medicare application is not required if both parents are undocumented immigrants).

   - All MHCP recipients are eligible for acute and maintenance dialysis.
   - Medicare covered patients who have not reached age 65, who suffer from end stage renal disease. ESRD benefits include all Part A and B items and services covered under the Medicare program. For dually eligible Medicare/Medicaid recipients, MA pays the coinsurance and deductibles amounts.
   - MA recipients under age 65 who do not meet the two year disability requirements, but need
dialysis or renal transplantation for treatment of end-stage renal disease, may be eligible for Medicare when one of the following conditions are met:

- Entitlement begins after a three-month waiting period, if a transplant or dialysis is not needed before the three-month period ends.
- Entitlement begins before the three-month waiting period, if the patient needs a transplant, receives self-dialysis training, and begins the first course of self-dialysis.

Non-Covered Services: The following are not covered when provided by a dialysis facility:

- Items or services not medically necessary for the diagnosis or treatment of ESRD or do not improve the patient’s condition.
- Hemoprofusion used to improve the results of hemodialysis or in conjunction with DFO to remove iron overload.
- Apheresis used before or after kidney transplant services.
- Missed appointments. If the facility prepares for a dialysis treatment, but the treatment is never provided, no payment is made.

CLINICAL EVIDENCE:

SUMMARY:

HHD appears to be relatively safe for a well-trained patient who adheres to the treatment regimen and who follows instructions for maintenance of the dialysis equipment. The complication rate, including the incidence of vascular access complications, was similar for HHD and conventional HD; however, there is a paucity of evidence on possible complications related to HHD.

There is some evidence that HHD might be an efficacious alternative to conventional HD and may provide health benefits for patients with relatively stable end-stage renal disease who are capable of completing training and adhering to the treatment regimen and who have sufficient social and familial support. Despite these promising findings, inherent weaknesses in the design and execution of the studies hampered interpretation of the data on efficacy and safety. For example, patients were highly selected and, in some cases, self-selected, which creates the possibility that the improved outcomes for HHD compared with conventional HD were related to the selection of healthier or more motivated patients and not to the therapy itself. HHD has been studied in a relatively small number of patients, and there is a lack of adequate control groups. Interstudy comparisons were complicated by the variability in dialysis methods and regimens, as well as outcome measures. Few studies have systematically evaluated the possible complications of HHD, and there remain uncertainties regarding the long-term impact of this therapy on cardiovascular outcomes, one of the major causes of death in ESRD patients, and on patient survival. Therefore, although HHD might benefit highly selected patients with ESRD, the optimal clinical role of this therapy remains undefined due to weaknesses of the available evidence. No well-designed studies have determined the long-term impact of this therapy on clinically relevant outcomes such as cardiovascular disease and survival. Definitive patient selection criteria for HHD have not been established due to weaknesses of the available evidence.
The Current Procedural Terminology (CPT®) codes and HCPCS codes listed in this policy are for reference purposes only. Listing of a service or device code in this policy does not imply that the service described by this code is a covered or non-covered health service. The inclusion of a code does not imply any right to reimbursement or guarantee claims payment. Other medical policies and coverage determination guidelines may apply.

### HCPCS Codes

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<td>Hemodialysis treatment performed less than 3 times per week or greater than 3 times per week</td>
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<td>Q4081</td>
<td>Injection, epoetin alfa, 100 units (for ESRD on dialysis)</td>
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### ICD-9 Codes

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<td>Rapidly progressive nephritic syndrome with dense deposit disease</td>
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<td>N01.7</td>
<td>Rapidly progressive nephritic syndrome with diffuse crescentic glomerulonephritis</td>
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<td>N01.8</td>
<td>Rapidly progressive nephritic syndrome with other morphologic changes</td>
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<td>Hemodialysis procedure with single evaluation by a physician or other qualified health care professional</td>
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<td>Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription</td>
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<tr>
<td>90945</td>
<td>Dialysis procedure other than hemodialysis (e.g., peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), with single evaluation by a physician or other qualified health care professional</td>
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<tr>
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<td>Dialysis procedure other than hemodialysis (e.g., peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies) requiring repeated evaluation by a physician or other qualified health care professional, with or without substantial revision of dialysis prescription</td>
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<td>90951</td>
<td>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 visits by a physician or other qualified health care professional per month</td>
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<td>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 visits by a physician or other qualified health care professional per month</td>
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<td>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 visit by a physician or other qualified health care professional per month</td>
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<tr>
<td>90954</td>
<td>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 visits by a physician or other qualified health care professional per month</td>
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<td>90957</td>
<td>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 visits by a physician or other qualified health care professional per month</td>
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<td>End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face visits by a physician or other qualified health care professional per month</td>
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<td>End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 2-3 face-to-face visits by a physician or other qualified health care professional per month</td>
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<td>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</td>
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<td>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</td>
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<td>End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older</td>
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<td>90967</td>
<td>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</td>
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<td>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</td>
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<td>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</td>
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<td>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</td>
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<tr>
<td>90989</td>
<td>Dialysis training, patient, including helper where applicable, any mode, completed course</td>
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<tr>
<td>90993</td>
<td>Dialysis training, patient, including helper where applicable, any mode, course not completed, per training session</td>
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<tr>
<td>90997</td>
<td>Hemoperfusion (e.g., with activated charcoal or resin)</td>
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<td>90999</td>
<td>Unlisted dialysis procedure, inpatient or outpatient</td>
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<td>99512</td>
<td>Home visit for dialysis</td>
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CPT® is a registered trademark of the American Medical Association.

REFERENCES:


24. Home Dialysis and Associated Technologies, Cigna Medical Coverage Policy.


**POLICY HISTORY:**

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<td>Reviewed and approved by the Quality Improvement Advisory and Credentialing Council (QIACC).</td>
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<td>11/25/2013</td>
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<td>1/09/2016</td>
<td>Policy updated and approved by the Interim Medical Policy Committee.</td>
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<td>1/28/2016</td>
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QUESTIONS AND ANSWERS:

Q1:  
A1:  

ATTACHMENTS: