Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP-027		
Subject:	Hemodialysis and Peritoneal Dialysis		
Effective Date:	February 5, 2018	**End Date:**	
Issue Date:	January 5, 2026	**Revised Date:**	January 2026
Date Reviewed:	September 2025		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Claim Type	**UB**	☒	**1500**	☒			

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan.

REIMBURSEMENT GUIDELINES:

This policy provides direction on the Plan's reimbursement for the two types of dialysis most commonly in use, hemodialysis, and peritoneal dialysis whether billed by a facility or by a professional.

Single evaluation

A single evaluation is a standard "uncomplicated" dialysis session where the physician visits/evaluates the patient but does not perform any other service for the patient during that dialysis session.

Applicable codes: 90935 90945 G0491 G0492

Repeated evaluations

Evaluations that are intended to represent a "complicated" dialysis session with, or without, substantial revision of dialysis prescription. The physician may visit the patient several times during a session and may also adjust the dialysis prescription.

Applicable codes: 90937 90947 G0491

Evaluation and Management Visits

Evaluation and Management (E/M) visits provided on the same day as outpatient dialysis procedures by the same facility, professional provider, professional provider group, or an associated contractor of the facility or professional provider are not eligible for separate reimbursement if they are related to the dialysis procedure. Reimbursement for those E/M visits is included in the allowance for the dialysis procedure with physician evaluation.

Applicable E/M codes:

90935	90937	90940	90945	90947	99202	99203	99204	99205
99211	99212	99213	99214	99215	99281	99282	99283	99284
99285	99288	99341	99342	99344	99345	99347	99348	99349
99350	99381	99382	99383	99384	99385	99386	99387	99391
99392	99393	99394	99395	99396	99397	99401	99402	99403
99404	99411	99412	99429	99485	99486	99499	G0380	G0381
G0382	G0383	G0384						

When the severity of the renal condition requires the patient to be hospitalized, E/M visits provided on the same day as dialysis procedures by the same facility, professional provider, professional provider group or an associated contractor of the facility or professional provider are not eligible for separate reimbursement. Reimbursement for E/M visits related to the renal condition requiring hospitalization is included in the allowance for the dialysis procedure with physician evaluation.

Applicable codes:

90935	90937	90940	90945	90947	99221	99222	99223	99231
99232	99233	99291	99292					

Modifier 25 and FT Exception

If the E/M visits and medical care are for unrelated non-renal conditions, modifier 25 may be appended to identify the E/M visit or other medical care as significant and separately identifiable from the other service(s) provided on the same day. Modifier FT may be reported for an unrelated E/M visit during a postoperative period, or on the same day as a procedure or another E/M visit.

When modifier 25 or FT are reported, the patient's records must clearly document that separately identifiable medical care was rendered and unrelated to the dialysis procedure or renal failure, which cannot be rendered during the dialysis session. Medical necessity for services appended with modifier 25 will be determined through a medical review.

ADDITIONAL REIMBURSEMENT GUIDELINES:

1. Claims for an unscheduled or emergency dialysis treatment for an End Stage Renal Disease (ESRD) patient in a hospital outpatient department that is not an ESRD facility should be processed using code G0257.

   Note: New York does not reimburse G0257 for the scenario above.

2. Continuous Ambulatory Peritoneal Dialysis (CAPD) is a method of dialysis performed by the patient. If a hospitalized CAPD patient requires assistance in this self-dialysis technique, it can be provided by hospital staff. Consequently, charges billed by a physician for CAPD sessions regardless of the place of service should be denied. Inpatient medical care rendered on a fee-for-service basis is eligible.

3. The following related services performed in conjunction with dialysis are not separately reimbursed:
    - Self-dialysis sessions (no codes)
    - Staff-assisted dialysis sessions (no codes)
    - Monthly maintenance care
    - Home visit for hemodialysis
    - Dialysis training
    - Connecting tube administration set, change by physician (no code)
    - Catheter site inspection by physician (no code)
    - Examination by physician for peritonitis (no code)
    - Physician review of CAPD apparatus and/or technique (no code)
    - Hemodialysis access flow study to determine blood flow in grafts and arteriovenous fistulae by an indicator dilution method

Applicable codes:

90940	90951	90952	90953	90954	90955	90956	90957	90958
90959	90960	90961	90962	90963	90964	90965	90966	90967
90968	90969	90970	90989	90993	90999	99512	S9335	S9339

DEFINITIONS:

Term	Definition
End-Stage Renal Disease (ESRD)	A medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life.
Continuous Ambulatory Peritoneal Dialysis (CAPD)	Peritoneal dialysis involving the continuous presence of dialysis solution in the peritoneal cavity.
Peritoneal Dialysis	A type of hemodialysis in which the peritoneum surrounding the abdominal cavity is used as a dialyzing membrane for removal of waste products or toxins accumulated as a result of renal failure.
Hemodialysis	The use of principles of dialysis for removal of certain elements from the blood while it is being circulated outside the body in a hemodialyzer or through the peritoneal cavity. The procedure is used to remove toxic wastes from the blood of a patient with acute or chronic renal failure.
Renal Failure	Inability of the kidney to maintain normal function, so that waste products and metabolites accumulate in the blood.

Modifier	Definition
FT	Unrelated Evaluation and Management (E/M) visit during a postoperative period, or on the same day as a procedure or another E/M visit.
25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service.

RELATED POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-009: Modifiers 25, 59, XE, XP, XS, XU, FT
- RP-035: Correct Coding Guidelines
- RP-063: Consultation Services

POLICY UPDATE HISTORY INFORMATION:

2 / 2018	Implementation
1 / 2021	Added notification regarding COVID-19 temporary policy waiver for codes indicated
11 / 2021	Added NY region applicable to the policy and added note for code G0257
1 / 2022	Added modifier FT
1 / 2023	Removed codes 99217-99220, 99241, 99251, 99324-99328, 99334-99337, 99343
7 / 2023	Removed policy exception notes pertaining to the PHE and added a definitions section
1 / 2026	Removed codes 99242-99245 and 99252-99255. Added codes 90993, 90999, 99233, 99291, 99292, 99341, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, S9335, S9339. Policy made applicable to Medicare Advantage.

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-027		
Subject:	Hemodialysis and Peritoneal Dialysis		
Effective Date:	February 5, 2018	**End Date:**	
Issue Date:	July 10, 2023	**Revised Date:**	July 2023
Date Reviewed:	May 2023		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☐	**WV**	☐	**DE**	☐	**NY**	☐
Applicable Claim Type	**UB**	☒	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

This policy provides direction on the Plan's reimbursement for the two types of dialysis most commonly in use, hemodialysis, and peritoneal dialysis.

REIMBURSEMENT GUIDELINES:

Single evaluation

A single evaluation is a standard "uncomplicated" dialysis session where the physician visits/evaluates the patient but does not perform any other service for the patient during that dialysis session.

Applicable codes: 90935 90945 G0491 G0492

Repeated evaluations

Evaluations that are intended to represent a "complicated" dialysis session with, or without, substantial revision of dialysis prescription. The physician may visit the patient several times during a session and may also adjust the dialysis prescription.

Applicable codes: 90937 90947 G0491

Consultations and medical visits

Consultations and medical visits provided on the same day as out-patient dialysis procedures by the same provider, provider group, or his or her associate, are not eligible for separate reimbursement.

Payment for those services is included in the allowance for the dialysis procedure with physician evaluation.

Applicable codes:

90935	90937	90940	90945	90947	99202	99203	99204	99205
99211	99212	99213	99214	99215	99242	99243	99244	99245
99281	99282	99283	99284	99285	99288	99342	99344	99345
99347	99348	99349	99350	99381	99382	99383	99384	99385
99386	99401	*99402	*99403	*99404	*99411	*99412	99429	99485
99486	99499	G0380	G0381	G0382	G0383	G0384		

When the severity of the renal condition requires the patient to be hospitalized, inpatient consultations and medical visits provided on the same day as dialysis procedures by the same provider, provider group, or his or her associate, are not eligible for separate reimbursement. Payment for those services is included in the allowance for the dialysis procedure with physician evaluation.

Applicable codes:

*99221	*99222	*99223	99231	99232	99252	99253	99254	99255
90935	90937	90940	90945	90947				

Modifier 25 and FT Exception

If the consultations and medical care are for a non-renal condition, modifier 25 may be appended with medical care (e.g. visits, consults) to identify it as significant and separately identifiable from the other service(s) provided on the same day. Modifier FT may be reported for an unrelated evaluation and management (e/m) visit during a postoperative period, or on the same day as a procedure or another e/m visit.

When modifier 25 or FT are reported, the patient's records must clearly document that separately identifiable medical care was rendered and unrelated to the dialysis procedure or renal failure, which cannot be rendered during the dialysis session. Medical necessity for services appended with modifier 25 will be determined through a medical review.

Additional Reimbursement Guidelines

1. Claims for an unscheduled or emergency dialysis treatment for an ESRD patient in a hospital outpatient department that is not an ESRD facility should be processed using code G0257.

   Note: New York does not reimburse G0257 for the scenario above.

2. CAPD is a method of dialysis performed by the patient. If a hospitalized CAPD patient requires assistance in this self-dialysis technique, it can be provided by hospital staff. Consequently, charges billed by a physician for CAPD sessions regardless of the place of service should be denied. Inpatient medical care rendered on a fee-for-service basis is eligible.

3. The following services performed in conjunction with dialysis are not covered:
   - Self-dialysis sessions (no codes)

- Staff-assisted dialysis sessions (no codes)
- Monthly maintenance care
- Home visit for hemodialysis
- Dialysis training
- Connecting tube administration set, change by physician (no code)
- Catheter site inspection by physician (no code)
- Examination by physician for peritonitis (no code)
- Physician review of CAPD apparatus and/or technique (no code)
- Hemodialysis access flow study to determine blood flow in grafts and arteriovenous fistulae by an indicator dilution method

Applicable codes:

90940	90951	90952	90953	90954	90955	90956	90957	90958
90959	90960	90961	90962	90963	90964	90965	90966	90967
90968	90969	90970	90989	99512				

Note: Hemodialysis/Peritoneal Dialysis is typically an outpatient procedure which is only eligible for coverage as an inpatient procedure in special circumstances, including, but not limited to, the presence of a co-morbid condition that would require monitoring in a more controlled environment such as the inpatient setting.

DEFINITIONS:

Term	Definition
End-Stage Renal Disease (ESRD)	A medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life.
Continuous Ambulatory Peritoneal Dialysis (CAPD)	Peritoneal dialysis involving the continuous presence of dialysis solution in the peritoneal cavity.
Peritoneal Dialysis	A type of hemodialysis in which the peritoneum surrounding the abdominal cavity is used as a dialyzing membrane for removal of waste products or toxins accumulated as a result of renal failure.
Hemodialysis	The use of principles of dialysis for removal of certain elements from the blood while it is being circulated outside the body in a hemodialyzer or through the peritoneal cavity. The procedure is used to remove toxic wastes from the blood of a patient with acute or chronic renal failure.
Renal Failure	Inability of the kidney to maintain normal function, so that waste products and metabolites accumulate in the blood.

Modifier	Definition
FT	Unrelated Evaluation and Management (E/M) visit during a postoperative period, or on the same day as a procedure or another E/M visit.
25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service.

RELATED HIGHMARK POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-009: Modifiers 25, 59, XE, XP, XS, XU, FT
- RP-035: Correct Coding Guidelines

POLICY UPDATE HISTORY INFORMATION:

2 / 2018	Implementation
1 / 2021	Added notification regarding COVID-19 temporary policy waiver for codes indicated
11 / 2021	Added NY region applicable to the policy and added note for code G0257
1 / 2022	Added modifier FT
1 / 2023	Removed codes 99217-99220, 99241, 99251, 99324-99328, 99334-99337, 99343
7 / 2023	Removed policy exception notes pertaining to the PHE and added a definitions section

Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP-027		
Subject:	Hemodialysis and Peritoneal Dialysis		
Effective Date:	February 5, 2018	**End Date:**	
Issue Date:	January 1, 2023	**Revised Date:**	January 2023
Date Reviewed:	December 2022		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☐	**WV**	☐	**DE**	☐	**NY** ☐
Applicable Claim Type	**UB**	☒	**1500**	☒			

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

Dialysis is a process by which waste products are removed from the body by diffusion from one fluid compartment to another across a semi-permeable membrane. The two types of dialysis commonly in use are hemodialysis and peritoneal dialysis. This policy provides direction on the Plan's reimbursement for these services.

REIMBURSEMENT GUIDELINES:

Single evaluation

A single evaluation is a standard "uncomplicated" dialysis session where the physician visits/evaluates the patient but does not perform any other service for the patient during that dialysis session.

Applicable codes: 90935 90945 G0491 G0492

Repeated evaluations

Evaluations that are intended to represent a "complicated" dialysis session with, or without, substantial revision of dialysis prescription. The physician may visit the patient several times during a session and may also adjust the dialysis prescription.

Applicable codes: 90937 90947 G0491

Consultations and medical visits

Consultations and medical visits provided on the same day as out-patient dialysis procedures by the same provider, provider group, or his or her associate, are not eligible for separate reimbursement. Payment for those services is included in the allowance for the dialysis procedure with physician evaluation.

Applicable codes:

90935	90937	90940	90945	90947	99202	99203	99204	99205
99211	99212	99213	99214	99215	99242	99243	99244	99245
99281	99282	99283	99284	99285	99288	99342	99344	99345
99347	99348	99349	99350	99381	99382	99383	99384	99385
99386	99401	*99402	*99403	*99404	*99411	*99412	99429	99485
99486	99499	G0380	G0381	G0382	G0383	G0384		

***Note**: In accordance with the telehealth waiver issued by The Centers for Medicare and Medicaid Services (CMS) related to the 2019 novel coronavirus, the Plan considers procedure codes 99401, 99402, 99403, 99404, 99411, and 99412, eligible to be performed as telemedicine beginning March 13, 2020, until the Public Health Emergency (PHE) declared by the Department of Health and Human Services (HHS) expires.

When the severity of the renal condition requires the patient to be hospitalized, inpatient consultations and medical visits provided on the same day as dialysis procedures by the same provider, provider group, or his or her associate, are not eligible for separate reimbursement. Payment for those services is included in the allowance for the dialysis procedure with physician evaluation.

Applicable codes:

*99221	*99222	*99223	99231	99232	99252	99253	99254	99255
90935	90937	90940	90945	90947				

***Note**: In accordance with the telehealth waiver issued by The Centers for Medicare and Medicaid Services (CMS) related to the 2019 novel coronavirus, the Plan considers procedure codes, 99221, 99222 and 99223, eligible to be performed as telemedicine beginning March 13, 2020, until the Public Health Emergency (PHE) declared by the Department of Health and Human Services (HHS) expires.

Modifier 25 and FT Exception

If the consultations and medical care are for a non-renal condition, modifier 25 may be appended with medical care (e.g. visits, consults) to identify it as significant and separately identifiable from the other service(s) provided on the same day. Modifier FT may be reported for an unrelated evaluation and management (e/m) visit during a postoperative period, or on the same day as a procedure or another e/m visit.

When modifier 25 or FT are reported, the patient's records must clearly document that separately identifiable medical care was rendered and unrelated to the dialysis procedure or renal failure, which cannot be rendered during the dialysis session. Medical necessity for services appended with modifier 25 will be determined through a medical review

Additional Reimbursement Guidelines

1. Claims for an unscheduled or emergency dialysis treatment for an ESRD patient in a hospital outpatient department that is not an ESRD facility should be processed using code G0257.

   Note: New York does not reimburse G0257 for the scenario above.

2. CAPD is a method of dialysis performed by the patient. If a hospitalized CAPD patient requires assistance in this self-dialysis technique, it can be provided by hospital staff. Consequently, charges billed by a physician for CAPD sessions regardless of the place of service should be denied. Inpatient medical care rendered on a fee-for-service basis is eligible.

3. The following services performed in conjunction with dialysis are not covered:
   - Self-dialysis sessions (no codes)
   - Staff-assisted dialysis sessions (no codes)
   - Monthly maintenance care
   - Home visit for hemodialysis
   - Dialysis training
   - Connecting tube administration set, change by physician (no code)
   - Catheter site inspection by physician (no code)
   - Examination by physician for peritonitis (no code)
   - Physician review of CAPD apparatus and/or technique (no code)
   - Hemodialysis access flow study to determine blood flow in grafts and arteriovenous fistulae by an indicator dilution method

Applicable codes:

90940	90951	90952	90953	90954	90955	90956	90957	90958
90959	90960	90961	90962	90963	90964	90965	90966	90967
90968	90969	90970	90989	99512				

Note: Hemodialysis/Peritoneal Dialysis is typically an outpatient procedure which is only eligible for coverage as an inpatient procedure in special circumstances, including, but not limited to, the presence of a co-morbid condition that would require monitoring in a more controlled environment such as the inpatient setting.

RELATED HIGHMARK POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-009: Modifiers 25, 59, XE, XP, XS, XU, FT

POLICY UPDATE HISTORY INFORMATION:

2 / 2018	Implementation
1 / 2021	Added notification regarding COVID-19 temporary policy waiver for codes indicated.
11 / 2021	Added NY region applicable to the policy and added note for code G0257.
1 / 2022	Added modifier FT
1 / 2023	Removed codes 99217-99220, 99241, 99251, 99324-99328, 99334-99337, 99343

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-027		
Subject:	Hemodialysis and Peritoneal Dialysis		
Effective Date:	February 5, 2018	**End Date:**	
Issue Date:	January 10, 2022	**Revised Date:**	January 2022
Date Reviewed:	December 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☐	**WV**	☐	**DE**	☐	**NY** ☐
Applicable Claim Type	**UB**	☒	**1500**	☒			

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

Dialysis is a process by which waste products are removed from the body by diffusion from one fluid compartment to another across a semi-permeable membrane. The two types of dialysis commonly in use are hemodialysis and peritoneal dialysis. This policy provides direction on the Plan's reimbursement for these services.

REIMBURSEMENT GUIDELINES:

Single evaluation

A single evaluation is a standard "uncomplicated" dialysis session where the physician visits/evaluates the patient but does not perform any other service for the patient during that dialysis session.

Applicable codes: 90935 90945 G0491 G0492

Repeated evaluations

Evaluations that are intended to represent a "complicated" dialysis session with, or without, substantial revision of dialysis prescription. The physician may visit the patient several times during a session and may also adjust the dialysis prescription.

Applicable codes: 90937 90947 G0491

Consultations and medical visits

Consultations and medical visits provided on the same day as out-patient dialysis procedures by the same provider, provider group, or his or her associate, are not eligible for separate reimbursement. Payment for those services is included in the allowance for the dialysis procedure with physician evaluation.

Applicable codes:

90935	90937	90940	90945	90947	99202	99203	99204	99205
99211	99212	99213	99214	99215	99241	99242	99243	99244
99245	99281	99282	99283	99284	99285	99288	99324	99325
99326	99327	99328	99334	99335	99336	*99337	99342	99343
99344	99345	99347	99348	99349	99350	99381	99382	99383
99384	99385	99386	*99401	*99402	*99403	*99404	*99411	*99412
99429	99485	99486	99499	G0380	G0381	G0382	G0383	G0384

***Note**: In accordance with the telehealth waiver issued by The Centers for Medicare and Medicaid Services (CMS) related to the 2019 novel coronavirus, the Plan considers procedure codes 99401, 99402, 99403, 99404, 99411, 99412 and 99337, eligible to be performed as telemedicine beginning March 13, 2020, until the Public Health Emergency (PHE) declared by the Department of Health and Human Services (HHS) expires.

When the severity of the renal condition requires the patient to be hospitalized, inpatient consultations and medical visits provided on the same day as dialysis procedures by the same provider, provider group, or his or her associate, are not eligible for separate reimbursement. Payment for those services is included in the allowance for the dialysis procedure with physician evaluation.

Applicable codes:

*99217	*99218	*99219	*99220	*99221	*99222	*99223	99231	99232
99251	99252	99253	99254	99255	90935	90937	90940	90945
90947								

***Note**: In accordance with the telehealth waiver issued by The Centers for Medicare and Medicaid Services (CMS) related to the 2019 novel coronavirus, the Plan considers procedure codes 99217, 99218, 99219, 99220, 99221, 99222 and 99223, eligible to be performed as telemedicine beginning March 13, 2020, until the Public Health Emergency (PHE) declared by the Department of Health and Human Services (HHS) expires.

Modifier 25 and FT Exception

If the consultations and medical care are for a non-renal condition, modifier 25 may be appended with medical care (e.g. visits, consults) to identify it as significant and separately identifiable from the other service(s) provided on the same day. Modifier FT may be reported for an unrelated evaluation and management (e/m) visit during a postoperative period, or on the same day as a procedure or another e/m visit.

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Additional Reimbursement Guidelines

1. Claims for an unscheduled or emergency dialysis treatment for an ESRD patient in a hospital outpatient department that is not an ESRD facility should be processed using code G0257.

   Note: New York does not reimburse G0257 for the scenario above.

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3. The following services performed in conjunction with dialysis are not covered:
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   - Monthly maintenance care
   - Home visit for hemodialysis
   - Dialysis training
   - Connecting tube administration set, change by physician (no code)
   - Catheter site inspection by physician (no code)
   - Examination by physician for peritonitis (no code)
   - Physician review of CAPD apparatus and/or technique (no code)
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Applicable codes:

90940	90951	90952	90953	90954	90955	90956	90957	90958
90959	90960	90961	90962	90963	90964	90965	90966	90967
90968	90969	90970	90989	99512				

Note: Hemodialysis/Peritoneal Dialysis is typically an outpatient procedure which is only eligible for coverage as an inpatient procedure in special circumstances, including, but not limited to, the presence of a co-morbid condition that would require monitoring in a more controlled environment such as the inpatient setting.

RELATED HIGHMARK POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-009: Modifiers 25, 59, XE, XP, XS, XU, FT

POLICY UPDATE HISTORY INFORMATION:

2 / 2018	Implementation
1 / 2021	Added notification regarding COVID-19 temporary policy waiver for codes indicated.
11 / 2021	Added NY region applicable to the policy and added note for code G0257.
1 / 2022	Added modifier FT

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-027		
Subject:	Hemodialysis and Peritoneal Dialysis		
Effective Date:	February 5, 2018	**End Date:**	
Issue Date:	November 1, 2021	**Revised Date:**	July 2021
Date Reviewed:	July 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☐	**WV**	☐	**DE**	☐	**NY** ☐
Applicable Claim Type	**UB**	☒	**1500**	☒			

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this Policy.

PURPOSE:

Dialysis is a process by which waste products are removed from the body by diffusion from one fluid compartment to another across a semi-permeable membrane. The two types of dialysis commonly in use are hemodialysis and peritoneal dialysis. This policy provides direction on the Plan's reimbursement for these services.

REIMBURSEMENT GUIDELINES:

Single evaluation

A single evaluation is a standard "uncomplicated" dialysis session where the physician visits/evaluates the patient but does not perform any other service for the patient during that dialysis session.

Applicable codes: 90935 90945 G0491 G0492

Repeated evaluations

Evaluations that are intended to represent a "complicated" dialysis session with, or without, substantial revision of dialysis prescription. The physician may visit the patient several times during a session and may also adjust the dialysis prescription.

Applicable codes: 90937 90947 G0491

Consultations and medical visits

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Payment for those services is included in the allowance for the dialysis procedure with physician evaluation.

Applicable codes:

90935	90937	90940	90945	90947	99202	99203	99204	99205
99211	99212	99213	99214	99215	99241	99242	99243	99244
99245	99281	99282	99283	99284	99285	99288	99324	99325
99326	99327	99328	99334	99335	99336	*99337	99342	99343
99344	99345	99347	99348	99349	99350	99381	99382	99383
99384	99385	99386	*99401	*99402	*99403	*99404	*99411	*99412
99429	99485	99486	99499	G0380	G0381	G0382	G0383	G0384

***Note**: In accordance with the telehealth waiver issued by The Centers for Medicare and Medicaid Services (CMS) related to the 2019 novel coronavirus, the Plan considers procedure codes 99401, 99402, 99403, 99404, 99411, 99412 and 99337, eligible to be performed as telemedicine beginning March 13, 2020, until the Public Health Emergency (PHE) declared by the Department of Health and Human Services (HHS) expires.

When the severity of the renal condition requires the patient to be hospitalized, inpatient consultations and medical visits provided on the same day as dialysis procedures by the same provider, provider group, or his or her associate, are not eligible for separate reimbursement. Payment for those services is included in the allowance for the dialysis procedure with physician evaluation.

Applicable codes:

*99217	*99218	*99219	*99220	*99221	*99222	*99223	99231	99232
99251	99252	99253	99254	99255	90935	90937	90940	90945
90947								

***Note**: In accordance with the telehealth waiver issued by The Centers for Medicare and Medicaid Services (CMS) related to the 2019 novel coronavirus, the Plan considers procedure codes 99217, 99218, 99219, 99220, 99221, 99222 and 99223, eligible to be performed as telemedicine beginning March 13, 2020, until the Public Health Emergency (PHE) declared by the Department of Health and Human Services (HHS) expires.

Modifier 25 Exception

If the consultations and medical care are for a non-renal condition, modifier 25 may be appended with medical care (e.g. visits, consults) to identify it as significant and separately identifiable from the other service(s) provided on the same day. When modifier 25 is reported, the patient's records must clearly document that separately identifiable medical care was rendered and unrelated to the dialysis procedure or renal failure, which cannot be rendered during the dialysis session. Medical necessity for services appended with modifier 25 will be determined through a medical review

Additional Reimbursement Guidelines

1. Claims for an unscheduled or emergency dialysis treatment for an ESRD patient in a hospital outpatient department that is not an ESRD facility should be processed using code G0257.

   Note: New York does not reimburse G0257 for the scenario above.

2. CAPD is a method of dialysis performed by the patient. If a hospitalized CAPD patient requires assistance in this self-dialysis technique, it can be provided by hospital staff. Consequently, charges billed by a physician for CAPD sessions regardless of the place of service should be denied. Inpatient medical care rendered on a fee-for-service basis is eligible.

3. The following services performed in conjunction with dialysis are not covered:
   - Self-dialysis sessions (no codes)
   - Staff-assisted dialysis sessions (no codes)
   - Monthly maintenance care
   - Home visit for hemodialysis
   - Dialysis training
   - Connecting tube administration set, change by physician (no code)
   - Catheter site inspection by physician (no code)
   - Examination by physician for peritonitis (no code)
   - Physician review of CAPD apparatus and/or technique (no code)
   - Hemodialysis access flow study to determine blood flow in grafts and arteriovenous fistulae by an indicator dilution method

Applicable codes:

90940	90951	90952	90953	90954	90955	90956	90957	90958
90959	90960	90961	90962	90963	90964	90965	90966	90967
90968	90969	90970	90989	99512				

Note: Hemodialysis/Peritoneal Dialysis is typically an outpatient procedure which is only eligible for coverage as an inpatient procedure in special circumstances, including, but not limited to, the presence of a co-morbid condition that would require monitoring in a more controlled environment such as the inpatient setting.

RELATED HIGHMARK POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-009: Modifiers 25, 59, XE, XP, XS and XU

POLICY UPDATE HISTORY INFORMATION:

2 / 2018	Implementation
1 / 2021	Added notification regarding COVID-19 temporary policy waiver for codes indicated.
11 / 2021	Added NY region applicable to the policy and added note for code G0257.

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSIONS

Bulletin Number:	RP-027		
Subject:	Hemodialysis and Peritoneal Dialysis		
Effective Date:	February 5, 2018	**End Date:**	
Issue Date:	January 25, 2021	**Revised Date:**	January 2021
Date Reviewed:	January 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV** ☒	**DE**	☒
Applicable Medicare Advantage Market	**PA**	☐	**WV** ☐		
Applicable Claim Type	**UB**	☒	**1500** ☒		

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this Policy.

REIMBURSEMENT GUIDELINES:

Dialysis is a process by which waste products are removed from the body by diffusion from one fluid compartment to another across a semi-permeable membrane. The two types of dialysis commonly in use are hemodialysis and peritoneal dialysis.

Single evaluation

A single evaluation is a standard "uncomplicated" dialysis session where the physician visits/evaluates the patient but, does not perform any other service for the patient during that dialysis session.

Applicable codes: 90935 90945 G0491 G0492

Repeated evaluations

Evaluations that are intended to represent a "complicated" dialysis session with, or without, substantial revision of dialysis prescription. The physician may visit the patient several times during a session and may also adjust the dialysis prescription.

Applicable codes: 90937 90947 G0491

Consultations and medical visits

Consultations and medical visits provided on the same day as out-patient dialysis procedures by the same provider, provider group, or his or her associate, are not eligible for separate reimbursement.

Payment for those services is included in the allowance for the dialysis procedure with physician evaluation.

Applicable codes:

90935	90937	90940	90945	90947	99202	99203	99204	99205
99211	99212	99213	99214	99215	99241	99242	99243	99244
99245	99281	99282	99283	99284	99285	99288	99324	99325
99326	99327	99328	99334	99335	99336	*99337	99342	99343
99344	99345	99347	99348	99349	99350	99381	99382	99383
99384	99385	99386	*99401	*99402	*99403	*99404	*99411	*99412
99429	99485	99486	99499	G0380	G0381	G0382	G0383	G0384

***Note**: In accordance with the telehealth waiver issued by The Centers for Medicare and Medicaid Services (CMS) related to the 2019 novel coronavirus, the Plan considers procedure codes 99401, 99402, 99403, 99404, 99411, 99412 and 99337, eligible to be performed as telemedicine beginning March 13, 2020, until the Public Health Emergency (PHE) declared by the Department of Health and Human Services (HHS) expires.

When the severity of the renal condition requires the patient to be hospitalized, inpatient consultations and medical visits provided on the same day as dialysis procedures by the same provider, provider group, or his or her associate, are not eligible for separate reimbursement. Payment for those services is included in the allowance for the dialysis procedure with physician evaluation.

Applicable codes:

*99217	*99218	*99219	*99220	*99221	*99222	*99223	99231	99232
99251	99252	99253	99254	99255	90935	90937	90940	90945
90947								

***Note**: In accordance with the telehealth waiver issued by The Centers for Medicare and Medicaid Services (CMS) related to the 2019 novel coronavirus, the Plan considers procedure codes 99217, 99218, 99219, 99220, 99221, 99222 and 99223, eligible to be performed as telemedicine beginning March 13, 2020, until the Public Health Emergency (PHE) declared by the Department of Health and Human Services (HHS) expires.

Modifier 25 Exception

If the consultations and medical care are for a non-renal condition, modifier 25 may be appended with medical care (e.g. visits, consults) to identify it as significant and separately identifiable from the other service(s) provided on the same day. When modifier 25 is reported, the patient's records must clearly document that separately identifiable medical care was rendered and unrelated to the dialysis procedure or renal failure, which cannot be rendered during the dialysis session. Medical necessity for services appended with modifier 25 will be determined through a medical review

Additional Reimbursement Guidelines

1. Claims for an unscheduled or emergency dialysis treatment for an ESRD patient in a hospital outpatient department that is not an ESRD facility should be processed using code G0257.

2. CAPD is a method of dialysis performed by the patient. If a hospitalized CAPD patient requires assistance in this self-dialysis technique, it can be provided by hospital staff. Consequently, charges billed by a physician for CAPD sessions regardless of the place of service should be denied. Inpatient medical care rendered on a fee-for-service basis is eligible.

3. The following services performed in conjunction with dialysis are not covered:
    - Self-dialysis sessions (no codes)
    - Staff-assisted dialysis sessions (no codes)
    - Monthly maintenance care
    - Home visit for hemodialysis
    - Dialysis training
    - Connecting tube administration set, change by physician (no code)
    - Catheter site inspection by physician (no code)
    - Examination by physician for peritonitis (no code)
    - Physician review of CAPD apparatus and/or technique (no code)
    - Hemodialysis access flow study to determine blood flow in grafts and arteriovenous fistulae by an indicator dilution method

Applicable codes:

90940	90951	90952	90953	90954	90955	90956	90957	90958
90959	90960	90961	90962	90963	90964	90965	90966	90967
90968	90969	90970	90989	99512				

Note: Hemodialysis/Peritoneal Dialysis is typically an outpatient procedure which is only eligible for coverage as an inpatient procedure in special circumstances, including, but not limited to, the presence of a co-morbid condition that would require monitoring in a more controlled environment such as the inpatient setting.

RELATED HIGHMARK POLICIES:

Refer to the following Reimbursement Policies for additional information:

- Reimbursement Policy RP-009: Modifiers 25, 59, XE, XP, XS and XU

POLICY UPDATE HISTORY INFORMATION:

2 / 2018	Implementation
1 / 2021	Added notification regarding COVID-19 temporary policy waiver for codes indicated.

Highmark Reimbursement Policy Bulletin

HIGHMARK.

CLICK HERE FOR HISTORY VERSIONS

Bulletin Number:	RP-027		
Subject:	Hemodialysis and Peritoneal Dialysis		
Effective Date:	February 5, 2018	**End Date:**	
Issue Date:	December 27, 2018	**Revised Date:**	December 18, 2018
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV** ☒	**DE**	☒
Applicable Medicare Advantage Market	**PA**	☐	**WV** ☐		
Applicable Claim Type	**UB**	☒	**1500** ☒		

Reimbursement Policy designation of Professional or Facility application is respective to how the provider is contracted with The Plan. Provider contractual agreement terms in direct conflict with this Reimbursement Policy may supersede this Policy's direction and regional applicability.

Dialysis is a process by which waste products are removed from the body by diffusion from one fluid compartment to another across a semi-permeable membrane. The two types of dialysis commonly in use are hemodialysis and peritoneal dialysis.

REIMBURSEMENT GUIDELINES:

Single evaluation

A single evaluation is a standard "uncomplicated" dialysis session where the physician visits/evaluates the patient but, does not perform any other service for the patient during that dialysis session.

Applicable codes: 90935 90945 G0491 G0492

Repeated evaluations

Evaluations that are intended to represent a "complicated" dialysis session with, or without, substantial revision of dialysis prescription. The physician may visit the patient several times during a session and may also adjust the dialysis prescription.

Applicable codes: 90937 90947 G0491

Consultations and medical visits

Consultations and medical visits provided on the same day as out-patient dialysis procedures by the same provider, provider group, or his or her associate, are not eligible for separate reimbursement. Payment for those services is included in the allowance for the dialysis procedure with physician evaluation.

Applicable codes:

90935	90937	90940	90945	90947	99201	99202	99203	99204
99205	99211	99212	99213	99214	99215	99241	99242	99243
99244	99245	99281	99282	99283	99284	99285	99288	99324
99325	99326	99327	99328	99334	99335	99336	99337	99342
99343	99344	99345	99347	99348	99349	99350	99381	99382
99383	99384	99385	99386	99401	99402	99403	99404	99411
99412	99429	99485	99486	99499	G0380	G0381	G0382	G0383
G0384								

When the severity of the renal condition requires the patient to be hospitalized, inpatient consultations and medical visits provided on the same day as dialysis procedures by the same provider, provider group, or his or her associate, are not eligible for separate reimbursement. Payment for those services is included in the allowance for the dialysis procedure with physician evaluation.

Applicable codes:

99217	99218	99219	99220	99221	99222	99223	99231	99232
99251	99252	99253	99254	99255	90935	90937	90940	90945
90947								

Modifier 25 Exception

If the consultations and medical care are for a non-renal condition, modifier 25 may be appended with medical care (e.g. visits, consults) to identify it as significant and separately identifiable from the other service(s) provided on the same day. When modifier 25 is reported, the patient's records must clearly document that separately identifiable medical care was rendered and unrelated to the dialysis procedure or renal failure, which cannot be rendered during the dialysis session. Medical necessity for services appended with modifier 25 will be determined through a medical review

Additional Reimbursement Guidelines

1. Claims for an unscheduled or emergency dialysis treatment for an ESRD patient in a hospital outpatient department that is not an ESRD facility should be processed using code G0257.

2. CAPD is a method of dialysis performed by the patient. If a hospitalized CAPD patient requires assistance in this self-dialysis technique, it can be provided by hospital staff. Consequently, charges billed by a physician for CAPD sessions regardless of the place of service should be denied. Inpatient medical care rendered on a fee-for-service basis is eligible.

3. The following services performed in conjunction with dialysis are not covered:
    - Self-dialysis sessions (no codes)
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    - Monthly maintenance care
    - Home visit for hemodialysis
    - Dialysis training
    - Connecting tube administration set, change by physician (no code)
    - Catheter site inspection by physician (no code)
    - Examination by physician for peritonitis (no code)
    - Physician review of CAPD apparatus and/or technique (no code)
    - Hemodialysis access flow study to determine blood flow in grafts and arteriovenous fistulae by an indicator dilution method

Applicable codes:

90940	90951	90952	90953	90954	90955	90956	90957	90958
90959	90960	90961	90962	90963	90964	90965	90966	90967
90968	90969	90970	90989	99512				

Note: Hemodialysis/Peritoneal Dialysis is typically an outpatient procedure which is only eligible for coverage as an inpatient procedure in special circumstances, including, but not limited to, the presence of a co-morbid condition that would require monitoring in a more controlled environment such as the inpatient setting.

RELATED HIGHMARK POLICIES:

Refer to the following Reimbursement Policies for additional information:

- Reimbursement Policy RP-009: Modifiers 25, 59, XE, XP, XS and XU

Highmark Reimbursement Policy Bulletin

Bulletin Number:	RP-027		
Subject:	Hemodialysis and Peritoneal Dialysis		
Effective Date:	February 5, 2018	**End Date:**	
Issue Date:	February 5, 2018		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒
Applicable Medicare Advantage Market	**PA**	☐	**WV**	☐		
Applicable Claim Type	**UB**	☒	**1500**	☒		

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Applicable codes:

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99205	99211	99212	99213	99214	99215	99241	99242	99243
99244	99245	99281	99282	99283	99284	99285	99288	99324
99325	99326	99327	99328	99334	99335	99336	99337	99342
99343	99344	99345	99347	99348	99349	99350	99381	99382
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99412	99429	99485	99486	99499	G0380	G0381	G0382	G0383
G0384								

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99251	99252	99253	99254	99255	90935	90937	90940	90945
90947								

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90959	90960	90961	90962	90963	90964	90965	90966	90967
90968	90969	90970	90983	90989	99512			

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