

Applies to:**Commercial Products**

- Harvard Pilgrim Health Care Commercial products
- Tufts Health Plan Commercial products

Public Plans Products

- Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product)
- Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans
- Tufts Health RITogether – A Rhode Island Medicaid Plan
- Tufts Health One Care – A dual-eligible product

Senior Products

- Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)
- Tufts Medicare Preferred HMO/PPO (Medicare Advantage products)

Policy

Tufts Health Plan covers medically necessary peritoneal and hemodialysis services¹, in accordance with the member's benefits. Medicare primary coverage commences after the patient's first 30 months of hemodialysis for Medicare eligible end stage renal disease (ESRD) members.

General Benefit Information

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider [website](#) or by contacting [Provider Services](#).

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

Commercial Products

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

Referral/Prior Authorization/notification Requirements

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

Commercial Products

Prior authorization is required for members to receive services from an out-of-network provider at the in-network level of benefits. For more information on prior authorization for out-of-network services, refer to the [Medical Necessity Guidelines for Out-of-Network Outpatient Dialysis at the In-Network Level of Benefits](#).

Senior Products and Tufts Health Public Plans

Prior authorization is not required for dialysis services for Senior Products or Tufts Health Public Plans. For more information, refer to the [Referral, Prior Authorization and Notification Policy](#).

¹ Dialysis services include, but are not limited to, labs, drugs, tubing change, adapter change and training related to hemodialysis and peritoneal dialysis (intermittent, continuous cycling and continuous ambulatory)
Dialysis

Billing Instructions

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

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

Compensation/Reimbursement Information

Providers are compensated according to the applicable network contracted rates and fee schedules.

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

The four severity factor adjustments used by Original Medicare (i.e., patient-level, onset of dialysis, outliers and facility-level) are not applied to the compensation rate.

Hemodialysis Frequency

Tufts Health Plan does not compensate for hemodialysis more than three times in a six-day period when billed with an office, home, temporary lodging, outpatient hospital, or ESRD treatment facility place of service.

Senior Products only

ESRD Facility - Hemodialysis Modifiers

Tufts Health Plan does not routinely compensate hemodialysis services (90999) when billed without modifier G1-G6 with Bill Type 0720-072Z (Clinic-hospital based or independent renal dialysis center) unless another claim line for the same procedure with modifier G1-G6 is also present on the claim.

Additional Resources

- [Coordination of Benefits Policy](#)
- [Solid Organ Transplant: Kidney Medical Necessity Guidelines](#)

Document History

- September 2022: Annual policy review; administrative updates
- September 2022: Annual policy review; removed ESRD PPS and E&M frequency edit language, as these follow industry standard claims
- July 2021: Policy reviewed by committee; template updates; added claim edit for ESRD facility hemodialysis modifiers (Senior Products only)
- June 2020: Reviewed by committee; added Tufts Health Public Plans and removed outdated billing instructions
- June 2018: Template updates
- January 2017: Template updates
- November 2016: Added language regarding authorization procedures for out of network services
- September 2015: Template conversion, template updates
- April 2015: Added Tufts Medicare Preferred HMO and Tufts Health Plan SCO; template updates

Background and Disclaimer Information

This policy applies to the products of Harvard Pilgrim Health Care and Tufts Health Plan and their affiliates, as identified in the check boxes on the first page for services performed by contracted providers.

Payment is based on member benefits and eligibility on the date of service, medical necessity review, where applicable, and the provider's network participation agreement with the Plan. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to Plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment.

Point32Health reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated as applicable;

please adhere to the most recent CPT and HCPCS coding guidelines.

We reserve the right to conduct audits on any provider and/or facility to ensure accuracy and compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, Harvard Pilgrim Health Care and Tufts Health Plan will expect the provider/facility to refund all payments related to noncompliance.