Priority Health	BILLING POLICY No. 129
FREQUENCY OF HEMODIALYSIS	
Date of origin: Aug. 2025	**Review dates: None yet recorded**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise specified
- Medicaid follows MDHHS unless otherwise specified

DEFINITION

This policy outlines billing and payment requirements regarding line item billing dialysis sessions for End Stage Renal Disease (ESRD) patients. This does not address line item billing for sessions associated with training or other modalities such as peritoneal dialysis.

MEDICAL POLICY

- End Stage Renal Disease / Renal Dialysis (#91526)

FOR MEDICARE

For indications that do not meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Click here for additional details on PSOD.

POLICY SPECIFIC INFORMATION

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

Coding specifics

Line item billing is required for all ESRD claims. Each dialysis session performed should be reported on a separate line.

Frequency

ESRD facilities furnishing dialysis treatments in-facility or in the Member's home are paid for up to 3 treatments per week.

For monthly claims submitted with Bill Type 72X and Revenue Codes 0821 and 0881, 3 approaches of billing per line are available. Based on the Patient's Plan of Care (POC), or other available medical documentation, the following outline should be followed when billing sessions. Note: Dialysis sessions in a member's plan of care that are not furnished should not be billed.

1. For dialysis sessions that have been furnished 3 times per week, each line should be 90999 without any modifiers appended. That is, when the hemodialysis-prescription is 3 times per week and each session is furnished, all of these sessions should be billed as 90999 (no modifier appended) and they will be paid as routine conventional dialysis up to 14 per month.

2. For each dialysis sessions furnished in addition to the 3 sessions per week that do not include medical documentation supporting a reasonable and necessary determination for payment, each line for these sessions should be billed as 90999 CG. Examples of when this could occur include short, more frequent treatments furnished for the convenience of the patient or staff, etc. Additional sessions need to be billed as 90999 CG when medical documentation has not been submitted to support the extra sessions as reasonable and necessary. The CG modifier indicates that the facility attests the additional treatment is not reasonable and necessary and should not receive additional payment. Each line billed as 90999 CG will be denied. However, the use of the modifier is used for data analysis. Please refer to CR 9989, Implementation of Modifier CG for Type of Bill 72X, dated May 12, 2017.
3. For each dialysis session furnished in addition to 3 sessions per week that includes medical documentation supporting a reasonable and necessary determination for payment, each line for these services should be billed as 90999 KX. These include medical conditions for acute and occasionally chronic conditions that have supporting documentation that the extra sessions are reasonable and necessary (e.g. through documents from recent hospital care, office visits, dialysis progress notes or MCP visits). These sessions must be reasonable and necessary for additional payment based on clinical conditions. On these claims, the 90999 lines without a modifier will be paid as 3X per week and those lines with 90999 KX will be considered for additional payments. Omission of the KX modifier will result in no additional payment for the line item.

The expectation is that these 3 scenarios will be seen on monthly claims, i.e., claims with 90999 lines only, or those with lines of 90999 mixed with 90999 CG or KX modifier appended. Ongoing data analysis may trigger provider specific requests for documentation should unusual patterns occur, i.e., claims with only lines of 90999 KX submitted.

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Please see our provider manual page for modifier use here.

- CG modifier indicates that the facility attests the additional treatment is not reasonable and necessary and should not receive additional payment. Each line billed as 90999 CG will be denied. However, the use CG modifier is used for data analysis.

- KX: Requirements specified in the medical policy have been met

Place of Service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Click here for additional information.

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. Go to the fee schedules (login required).

REFERENCES

Article A55703 Billing and Coding: Frequency of Hemodialysis

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made