Hemodialysis

Reimbursement Policy ID: RPC.0097.FLDS

Recent review date: 07/2026

Reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. The health plan may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT®); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy establishes reimbursement guidelines for the submission of hemodialysis treatments furnished by End-Stage Renal Disease (ESRD) facilities, whether provided in a facility setting or in the patient's home.

This policy does not apply to billing for training-related sessions or other dialysis modalities, including peritoneal dialysis.

Exceptions

N/A

Reimbursement Guidelines

ESRD facilities furnishing hemodialysis services in a facility setting or in the patient's home are reimbursable for up to 3 treatments per week.
Claims submitted on a weekly or monthly basis with Bill Type 72X and Revenue Codes 0821 or 0881 should be billed **per line**.

Claims for dialysis sessions may be submitted under the following 3 scenarios:

1. The patient's plan of care is hemodialysis 3 times per week. When each session is furnished, the session should be billed using 90999 without a modifier. These sessions will be reimbursed as routine dialysis services up to 13 or 14 times per month.*
2. Each dialysis session billed in addition to 3 sessions per week without medical record documentation supporting the additional sessions as reasonable and necessary should be billed using 90999 with modifier CG. Examples may include shorter sessions furnished for the convenience of the patient or staff. Use of modifier CG indicates that the additional services were not reasonable or necessary, and no additional reimbursement is expected.
3. Additional dialysis sessions above 13 or 14 per month that are reasonable and necessary and supported by medical record documentation should be submitted with 90999 and modifier KX on each applicable line to be considered for payment. Use of modifier KX confirms that the services were medically necessary after the allowable 13 or 14 sessions per month.*

These 3 scenarios are expected to appear on claims as lines with 90999 only or as lines with 90999 appended with modifier CG or modifier KX, as applicable. The plan of care (POC) and supporting medical record documentation should be maintained and may be requested.

For claims submitted weekly, the maximum allowance is 3 treatments per week. Any additional units billed without the applicable modifier will not be reimbursed. For claims submitted monthly, a maximum of 13 or 14 treatments per month is allowed, depending on the length of the calendar month. Units billed beyond the maximum will be denied unless submitted with the applicable modifier and supporting medical record documentation for the additional treatments.

*****Depending on length of the calendar month

Definitions

End Stage Renal Disease (ESRD)
End stage renal disease is the final, permanent stage of chronic kidney disease, where kidney function has declined to the point that the kidneys can no longer function on their own.

Hemodialysis
A medical procedure that removes waste products and excess fluid from the blood when the kidneys are unable to do so.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. Centers for Medicare and Medicaid Services (CMS).
V. The National Correct Coding Initiative (NCCI).
VI. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdId=37475&ver=17
VII. LCD 55354 Billing and Coding: Frequency of Hemodialysis

VIII. LCD 37475 Frequency of Hemodialysis
IX. Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c11.pdf
X. Medicare Fee Schedule(s).

Attachments

N/A

Associated Policies

N/A

Policy History

09/2026	• Removed the next review date • Replaced the plan name with “the health plan”
07/2026	Reimbursement Policy Committee Approval
07/2026	Annual review • No major changes
10/2025	Reimbursement Policy Committee Approval