Coverage Summary

Renal Services and Procedures

<table>
<thead>
<tr>
<th>Policy Number:</th>
<th>Products: UnitedHealthcare Medicare Advantage Plans</th>
<th>Original Approval Date: 07/16/2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>R-004</td>
<td>UnitedHealthcare Medicare Advantage Plans</td>
<td></td>
</tr>
<tr>
<td>Approved by:</td>
<td>UnitedHealthcare Medicare Benefit Interpretation Committee</td>
<td></td>
</tr>
<tr>
<td>Last Review Date: 09/17/2019</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Medicare Advantage Policy Guideline: Therapeutic Embolization (NCD 20.28)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This information is being distributed to you for personal reference. The information belongs to UnitedHealthcare and unauthorized copying, use, and distribution are prohibited. This information is intended to serve only as a general reference resource and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the Member’s Evidence of Coverage (EOC)/Summary of Benefits (SB). If there is a discrepancy between this policy and the member’s EOC/SB, the member’s EOC/SB provision will govern. The information contained in this document is believed to be current as of the date noted.

The benefit information in this Coverage Summary is based on existing national coverage policy, however, Local Coverage Determinations (LCDs) may exist and compliance with these policies are required where applicable.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

INDEX TO COVERAGE SUMMARY

<table>
<thead>
<tr>
<th>I. COVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Lithotripsy</td>
</tr>
<tr>
<td>2. Therapeutic Embolization</td>
</tr>
<tr>
<td>3. Face-to-Face Kidney Disease Education (KDE)</td>
</tr>
</tbody>
</table>

| II. DEFINITIONS |
| III. REFERENCES |
| IV. REVISION HISTORY |

I. COVERAGE

Coverage Statement: Renal services and procedures are covered when Medicare coverage criteria are met.

Guidelines/Notes:

1. Lithotripsy

   In addition to the traditional surgical/endoscopic techniques for the treatment of kidney stones, the following lithotripsy techniques are also covered:

   a. Extracorporeal Shock Wave Lithotripsy (ESWL) for use in the treatment of upper urinary tract kidney stones

   b. Percutaneous lithotripsy (or nephrolithotomy) of kidney stones by ultrasound or by the related techniques of electrohydraulic or mechanical lithotripsy

   c. Transurethral ureteroscopic lithotripsy for the treatment of urinary tract stones of the kidney
2. **Therapeutic Embolization**

Therapeutic embolization is covered when done for hemorrhage and for other conditions amenable to treatment by the procedure, when reasonable and necessary for the individual patient. Renal embolization for the treatment of renal adenocarcinoma continues to be covered, effective December 15, 1978, as one type of therapeutic embolization:

a. Hemorrhage is covered and other conditions amenable to this treatment.

b. Renal embolization for renal adenocarcinoma to:
   - Reduce tumor vascularity preoperatively;
   - Reduce tumor bulk in inoperable cases; or Palliate specific symptoms

See the [NCD Therapeutic Embolization (20.28)](Accessed August 29, 2019)

3. **Face-to-Face Kidney Disease Education (KDE)**

**Eligibility for Coverage**

Face to face KDE services are covered for the following:

- Patient diagnosed with Stage IV CKD, using the Modification of Diet in Renal Disease (MDRD) Study formula (severe decrease in GFR, GFR value of 15-29 mL/min/1.73 m²), and
- Patient with a referral from the physician managing the patient’s kidney condition. The referral should be documented in the patient’s medical records.

**Qualified Person**

KDE services provided by a ‘qualified person’ are covered; qualified person meaning a:

- Physician (as defined in Section 30 of the Medicare Benefit Policy Manual Chapter 15),
- Physician assistant, nurse practitioner, or clinical nurse specialist (as defined in Sections 190, 200, and 210 of the Medicare Benefit Policy Manual Chapter 15),
- Hospital, critical access hospital (CAH), skilled nursing facility (SNF), comprehensive outpatient rehabilitation facility (CORF), home health agency (HHA), or hospice, if the KDE services are provided in a rural area (using the actual geographic location core based statistical area (CBSA) to identify facilities located in rural areas), or
- Hospital or CAH that is treated as being rural (was reclassified from urban to rural status per 42 CFR 412.103).

The “incident to” requirements at section 1861(s) (2) (A) of the Social Security Act (the Act) do not apply to KDE services. The following providers are not ‘qualified persons’ and are excluded from furnishing KDE services

- A hospital, CAH, SNF, CORF, HHA, or hospice located outside of a rural area (using the actual geographic location CBSA to identify facilities located outside of a rural area), unless the services are furnished by a hospital or CAH that is treated as being in a rural area; and
- Renal dialysis facilities.

**Limitations for Coverage**

- KDE are covered services up to six (6) sessions as a patient lifetime maximum. A session is 1 hour. In order to bill for a session, a session must be at least 31 minutes in duration. A session that lasts at least 31 minutes, but less than 1 hour still constitutes 1 session.
- On an individual basis or in group settings; if the services are provided in a group setting, a group consists of 2 to 20 individuals who not all need be UnitedHealthcare Medicare members.
HCPCS Codes

Two HCPCS codes were created for this benefit and one or the other must be present, along with the ICD codes for chronic kidney disease, Stage IV (severe), in order for a claim to be processed and paid correctly. They are:

- G0420: Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per one hour
- G0421: Face-to-face educational services related to the care of chronic kidney disease; group, per session, per one hour


For claims processing instructions, see the Medicare Claims Processing Manual, Chapter 32, Section 20 - Billing Requirements for Coverage of Kidney Disease Patient Education Services. (Accessed August 29, 2019)

II. DEFINITIONS

III. REFERENCES

See above

IV. REVISION HISTORY

09/17/2019 • Routine review; no change to coverage guidelines