

# Kidney Disease Education

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Related Medicare Advantage Coverage Summary
• <a href="#">Renal Services and Procedures</a>

## Policy Summary

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### Overview

Chronic kidney disease (CKD) is kidney damage for 3 months or longer, regardless of the cause of kidney damage. CKD typically evolves over a long period of time and patients may not have symptoms until significant, possibly irreversible, damage has been done. Complications can develop from kidneys that do not function properly, such as weak bones, anemia and high blood pressure. When CKD progresses, it may lead to kidney failure, which requires artificial means to perform kidney functions (dialysis) or a kidney transplant to maintain life.

Classified into 5 stages based on the patients glomerular filtration rate (GFR, how quickly blood is filtered through the kidneys), with stage I having kidney damage with normal or increased GFR to stage V with kidney failure, also called end-stage renal disease (ESRD). When patients with CKD are identified, treatment is available to help prevent complications of decreased kidney function, reduce the risk of other diseases such as heart disease, and slow the progression of kidney disease.

### Guidelines

Patients with CKD may benefit from kidney disease education (KDE) interventions due to the large amount of medical information that could affect patient outcomes, including the increasing emphasis on self-care and patients’ desire for informed, autonomous decision-making.

Pre-dialysis education can help patients achieve better understanding of their illness, dialysis modality options, and may help delay the need for dialysis. Education interventions should be patient-centered, offer support to the patient, encourage collaboration, and be delivered consistently.

Centers for Medicare & Medicaid Services (CMS) covers KDE services under Medicare Part B. KDE services are designed to provide beneficiaries with Stage IV CKD comprehensive information regarding: the management of comorbidities, prevention of uremic complications; including delaying the need for dialysis; all therapeutic options (each option for renal replacement therapy, dialysis access options, and transplantation); ensuring that the beneficiary has opportunities to actively participate in his/her choice of therapy; and that the services be tailored to meet the beneficiary’s needs.

Medicare Part B covers outpatient, face-to-face KDE services for a beneficiary that:

- Obtains a referral from the physician managing the beneficiary’s kidney condition. The referral should be documented in the beneficiary’s medical records.

- Is 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 m<sup>2</sup>), and

Medicare Part B covers KDE services provided by a ‘qualified person,’ meaning a:

- Physician (as defined in section 30 of Chapter 15 in the CMS Benefit Policy Manual),
- Physician assistant, nurse practitioner, or clinical nurse specialist (as defined in sections 190, 200, and 210 of Chapter 15 in the CMS Benefit Policy Manual),
- Hospital or CAH that is treated as being rural (was reclassified from urban to rural status per 42 CFR 412.103), or
- 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).

## Limitations for Coverage

Medicare Part B covers KDE services:

- Up to six (6) sessions as a beneficiary 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 need not all be Medicare beneficiaries.

Medicare Part B covers KDE services, provided by a qualified person, which provide comprehensive information regarding:

- A. The management of comorbidities, including delaying the need for dialysis, which includes, but is not limited to, the following topics:
  - Hypertension management,
  - Anemia management,
  - Bone disease and disorders of calcium and phosphorus metabolism management,
  - Prevention and treatment of cardiovascular disease,
  - Prevention and treatment of diabetes,
  - Symptomatic neuropathy management, and
  - Impairments in functioning and well-being.
- B. Prevention of uremic complications, which includes, but is not limited to, the following topics:
  - Information on how the kidneys work and what happens when the kidneys fail,
  - Understanding if remaining kidney function can be protected, preventing disease progression, and realistic chances of survival,
  - Medication review, including how each medication works, possible side effects and minimization of side effects, the importance of compliance, and informed decision making if the patient decides not to take a specific drug, and
  - Diet and fluid restrictions
- C. Therapeutic options, treatment modalities and settings, advantages and disadvantages of each treatment option, and how the treatments replace the kidney, including, but not limited to, the following topics:
  - Hemodialysis, both at home and in-facility;
  - Transplantation
  - Peritoneal dialysis (PD), including intermittent PD, continuous ambulatory PD, and continuous cycling PD, both at home and in-facility, and
  - All dialysis access options for hemodialysis and peritoneal dialysis
- D. Opportunities for beneficiaries to actively participate in the choice of therapy and be tailored to meet the needs of the individual beneficiary involved, which includes, but is not limited to:
  - Physical symptoms,
  - Exercise,
  - The right to refuse treatment,
  - Impact on work and finances,
  - Impact on family and social life,
  - The meaning of test results, and
  - Psychological impact.

## Outcomes Assessment

Qualified persons that provide KDE services must develop outcomes assessments that are designed to measure beneficiary knowledge about CKD and its treatment. The assessment must be administered to the beneficiary during a KDE session, and be made available to the (CMS) upon request. The outcomes assessments serve to assist KDE educators and CMS in improving subsequent KDE programs, patient understanding, and assess program effectiveness of:

- Meeting the communication needs of underserved populations, persons with limited English proficiency, including persons with disabilities, and persons with health literacy needs, and
- Preparing the beneficiary to make informed decisions about their healthcare options related to CKD.

## Applicable Codes

The following list(s) of codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline 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 the member specific benefit plan document 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.

HCPCS Code	Description
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

Diagnosis Code	Description
N18.4	Chronic kidney disease, stage 4 (severe)

## References

### CMS Benefit Policy Manual

[Chapter 15: § 310 Kidney Disease Patient Education Services](#)

### CMS Claims Processing Manual

[Chapter 32: § 20 Billing Requirements for Coverage of Kidney Disease Patient Education Services](#)

### CMS Transmittal(s)

[Transmittal 117, Change Request 6557, Dated 12/18/2009 \(Coverage of Kidney Disease Patient Education Services\)](#)

[Transmittal 178, Change Request 8553, Dated 12/30/2013 \(Expansion of Medicare Telehealth Services for CY 2014\)](#)

[Transmittal 1876, Change Request 6557, Dated 12/18/2009 \(Coverage of Kidney Disease Patient Education Services\)](#)

### MLN Matters

[Article MM6557, Coverage of Kidney Disease Patient Education Services](#)

### Other(s)

[National Kidney Disease Education Program \(NKDEP\), NIH Website](#)

[Patient Resources, National Kidney Disease Education Program, CMS Website](#)

[Telehealth Services, Article ICN901705, February 2018, CMS Website](#)

## Guideline History/Revision Information

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

Date	Summary of Changes
04/01/2021	<b>Template Update</b> <ul style="list-style-type: none"><li>Reformatted policy; transferred content to new template</li></ul>
09/09/2020	<ul style="list-style-type: none"><li>Routine review; no change to guidelines</li></ul> <b>Supporting Information</b> <ul style="list-style-type: none"><li>Archived previous policy version MPG183.05</li></ul>

## Purpose

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers' submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as NCDs, LCDs, LCAs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the [References](#) section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

## Terms and Conditions

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document\* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided.

UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

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\*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the [Administrative Guide](#).