Overview

Laboratory tests are essential to monitor the progress of CRD patients. The following list and frequencies of tests represent the level and types of routine laboratory tests that are covered. Bills for other types of tests are considered non-routine. Routine tests at greater frequencies must include medical justification. Non-routine tests generally are justified by the diagnosis.

- The routinely covered regimen includes the following tests:
  - Per Dialysis
    - All hematocrit or hemoglobin and clotting time tests furnished incident to dialysis treatments.
  - Per Week
    - Prothrombin time for patients on anticoagulant therapy
    - Serum Creatinine
  - Per Week or Thirteen Per Quarter
    - BUN
  - Monthly
    - CBC
    - Serum Calcium
    - Serum Potassium
    - Serum Chloride
    - Serum Bicarbonate
    - Serum Phosphorous
    - Total Protein
    - Serum Albumin
    - Alkaline Phosphatase
    - AST, SGOT
    - LDH
  - Guidelines for tests other than those routinely performed include:
    - Serum Aluminum - one every 3 months
    - Serum Ferritin - one every 3 months
  - The following tests for hepatitis B are covered when patients first enter a dialysis facility:
    - Hepatitis B surface antigen (HBsAg)
    - Anti-HBs

Coverage of future testing in these patients depends on their serologic status and on whether they have been successfully immunized against hepatitis B virus. The following table summarizes the frequency of serologic surveillance for hepatitis B. Tests furnished according to this table do not require additional documentation and are paid separately because payment for maintenance dialysis treatments does not take them into account.
Frequency of Screening

<table>
<thead>
<tr>
<th>Vaccination Status</th>
<th>Serologic Status</th>
<th>HBsAG Patients</th>
<th>Anti-HBs Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unvaccinated</td>
<td>Susceptible</td>
<td>Monthly</td>
<td>Semiannually</td>
</tr>
<tr>
<td>Unvaccinated</td>
<td>HBSAg Carrier</td>
<td>Annually</td>
<td>None</td>
</tr>
<tr>
<td>Unvaccinated</td>
<td>Anti-HBs-Positive¹</td>
<td>None</td>
<td>Annually</td>
</tr>
<tr>
<td>Vaccinated</td>
<td>Anti-HBs-Positive¹</td>
<td>None</td>
<td>Annually</td>
</tr>
<tr>
<td>Vaccinated</td>
<td>Low Level or No Anti-HBs</td>
<td>Monthly</td>
<td>Semiannually</td>
</tr>
</tbody>
</table>

¹At least 10 sample ration units by radioimmunoassay or positive by enzyme immunoassay

Beneficiaries who are in the process of receiving hepatitis B vaccines, but have not received the complete series, should continue to be routinely screened as susceptible. Between one and six months after the third dose, all vaccines should be tested for anti-HBs to confirm their response to the vaccine. Patients who have a level of anti-HBs of at least 10 sample ratio units (SRUs) by radioimmunoassay (RIA) or who are positive by enzyme immunoassay (EIA) are considered adequate responders to vaccine and need only be tested for anti-HBs annually to verify their immune status. If anti-HBs drops below 10 SRUs by RIA or is negative by EIA, a booster dose of hepatitis B vaccine should be given.

**Guidelines**

Laboratory tests are subject to the normal coverage requirements. If the laboratory services are performed by a free-standing facility; confirm it meets the conditions of coverage for independent laboratories.

**Coding Clarification:**
- Local Coverage Determinations (LCDs) and Local Coverage Articles (LCAs) criteria varies per jurisdiction for laboratory testing in CRD patients.
- An appropriate CPT/ICD-10 code must be submitted with each claim. Failure to do so may result in denial or delay in claim processing.
- The most current CPT/ICD-10 code(s) should be used to ensure proper payment.
- Please see the Policy Guideline [Clinical Diagnostic Laboratory Services](#) for additional coding and coverage guidelines.

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**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 LCDs, NCDs, 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.

**REFERENCES**

**CMS National Coverage Determinations (NCDs)**
- [NCD 190.10 Laboratory Tests - CRD Patients](#)
- Reference NCDs are numerous: [Lab National Coverage Determinations (NCDs) Alphabetical Index](#)

**CMS Benefit Policy Manual**
- [Chapter 11: §20.2 – Laboratory Services](#)
- [Chapter 15: § 80.1 Clinical Laboratory Services](#)

**CMS Claims Processing Manual**
- [Chapter 16; § 20 Calculation of Payment Rates - Clinical Laboratory Test Fee Schedules, § 40 Billing for Clinical Laboratory Tests, § 70 Clinical Laboratory Improvement Amendments (CLIA) Requirements, § 90.2 Organ or Disease Oriented Panels](#)

**UnitedHealthcare Commercial Policies**
- [Hepatitis Screening](#)
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.

<table>
<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/01/2019</td>
<td>• Reorganized policy template; relocated Terms and Conditions and Purpose section</td>
</tr>
<tr>
<td>03/13/2019</td>
<td>• Annual review</td>
</tr>
<tr>
<td></td>
<td>• CPT Code list removed from policy</td>
</tr>
</tbody>
</table>

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.