

September 12, 2007

## NON-VA DIALYSIS CARE

**1. PURPOSE:** This Veterans Health Administration (VHA) Directive establishes policy for the authorization and payment of dialysis care administered to veterans by non-Department of Veterans Affairs (VA) health care providers.

**2. BACKGROUND:** Dialysis as a result of End Stage Renal Disease (ESRD) is a service provided by VA as part of the veterans medical benefits package described in Title 38 Code of Federal Regulations (CFR) §17.38 (“Medical benefits package”). This benefit may be provided under Title 38 United States Code, (U.S.C.) § 1703 (“Contracts for hospital care and medical services in non-Department facilities”), which authorizes VA to provide needed medical care and services to eligible veterans when Department facilities are not capable of furnishing economical hospital care or medical services because of geographic inaccessibility, or are not capable of furnishing the care or services required. This benefit may be provided to enrolled veterans or otherwise eligible veterans in accordance with VA’s other contracting and sharing authorities. Dialysis is a limited resource within VA’s health care system; therefore, much of this care is purchased by VA from community resources. Due to the high cost of dialysis treatment and the significant expenditures by VA for this care, the Office of the Inspector General (OIG) recently conducted an audit of payments for non-VA dialysis care. The OIG Report Number 05-03037-107 dated March 21, 2006, recommended that the Under Secretary for Health ensure correction of inconsistencies in the provision and payment of non-VA dialysis. In order to correct the identified issues, this Directive provides specific instructions to ensure consistency with the authorization and payment principles of non-VA dialysis care.

**3. POLICY:** It is VHA policy to appropriately provide non-VA dialysis care to eligible veterans with ESRD and to process and pay for such care as provided in Attachment A and Attachment B. *NOTE: Questions regarding renal transplantation should be directed to the VA National Transplant Program Office, VA Central Office, Washington, DC 20420, at (800) 604-3278.*

**4. ACTION:** VA medical facility directors are responsible for establishment of written policies and procedures to ensure authorization and payment for non-VA dialysis care in accordance with the:

- a. Business rules established in Attachment A.
- b. Claims processing guidelines established in Attachment B.

## 5. REFERENCES:

- a. Title 38 U.S.C. §§ 1703, 1725, 1728, 7409, 8111, and 8153.

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b. Title 38 CFR §§ 17.38, 17.52, 17.56, 17.120-17.142, and 17.1000-17.108.

**6. FOLLOW-UP RESPONSIBILITY:** The Chief Business Office (16) is responsible for the contents of this Directive. Questions may be addressed to the National Fee Program Office, VHA CBO Field Office, Denver, CO 80209 or by calling (720) 889-2349.

**7. RESCISSIONS:** None. This VHA Directive expires September 30, 2012.

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## ATTACHMENT A

### BUSINESS RULES FOR NON-VA DIALYSIS CARE

#### 1. Definitions

a. **Authorized Care.** Authorized care is non-VA care or treatment approved in advance by VA.

b. **Contract.** A contract is a written agreement entered into by VA with a non-VA physician or facility to provide medical care and services to VA beneficiaries pursuant to Title 38 (U.S.C.) §§ 1703 (“Contracts for hospital care and medical services in non-Department facilities”), 7409 (“Contracts for scarce medical specialist services”), 8153 (“Sharing of health-care services”); or 8111 (“Sharing of Department of Defense health-care resources”). These contracts are to be carried out in accordance with Federal Acquisition regulations, as applicable.

c. **Foreign Medical Program (FMP).** FMP is VA program that authorizes care for the treatment of a veteran’s service-connected condition when the veteran is residing or sojourning outside of the United States (U.S.) and its territories.

d. **Individual Non-VA Provider Authorization.** Individual non-VA provider authorization is issued to a non-VA provider for the provision of specified medical services to an individual veteran.

e. **Non-VA Dialysis.** Non-VA Dialysis is service provided by non-VA health care providers in a non-VA facility.

f. **Unauthorized Care.** Unauthorized Care is non-VA emergency care or treatment not approved by VA prior to the care or treatment being provided to the veteran.

#### 2. Considerations for Non-VA Dialysis Care

a. Dialysis treatment is a covered benefit under VA’s medical benefits package, which is defined in Title 38 Code of Federal Regulation (CFR) § 17.38.

b. Appropriate non-VA dialysis care must be authorized for eligible veterans in need of such treatment when VA or other Federal facilities are not capable of furnishing economical hospital care or medical services because of geographic inaccessibility, or are not capable of furnishing the care or services required.

c. Individual Non-VA Provider authorizations are only to be used when a local facility determines the demand for care is not sufficient to support a contract or negotiated agreement. Because dialysis care must be provided on an ongoing, long-term basis, it generally should be authorized under a contract rather than on a fee for service basis.

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d. Reimbursement for unauthorized non-VA dialysis care may be approved under emergent medical circumstances for certain eligible veterans in accordance with 38 U.S.C. § 1725 (“Reimbursement for emergency treatment”) and § 1728, (“Reimbursement of certain medical expenses”).

e. In the absence of a contract payment of authorized non-VA dialysis treatment is assigned as provided by 38 CFR § 17.56 (“Payments for non-VA physician and other care professional services”) and can be electronically viewed at: <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=6dce11c643e846a76c91ac44a542db7d&rgn=div8&view=text&node=38:1.0.1.1.19.0.174.28&idno=38>

*NOTE: In cases of unauthorized care paid under 38 U.S.C. § 1725, the amount of payment is to be made in accordance with 38 CFR § 17.1005 (“Payment limitations”) which can be electronically viewed at: <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=6aa0407949fba4a5500a956a698285ab&rgn=div8&view=text&node=38:1.0.1.19.0.206.206&idno=38>*

f. When a contract is in place, the contracted agreement amount is to be paid.

g. Payment jurisdiction depends upon type of dialysis being provided:

(a) For authorized non-VA care or services obtained by contract, or individual authorization, the authorization, funds control, and payment processing for contract dialysis care are assigned to the VA facility clinic of jurisdiction maintaining the contract, or that issued the authorization.

(b) For unauthorized non-VA care or services, the VA facility closest to the non-VA provider of the unauthorized care has the jurisdictional responsibility for review and payment determination.

h. **IMPORTANT:** Veterans who have Medicare, Medicaid, or other Federal or State program coverage and are enrolled or otherwise eligible for VA medical care may choose to utilize either their Medicare, Medicaid, other Federal or State program coverage, or their VA benefit. While VA may discuss this option with the veteran, VA may not require or suggest that the veteran use Medicare or Medicaid coverage for dialysis care instead of obtaining such care through VA. However, veterans who choose to use their Medicare or Medicaid coverage, instead of VA benefits, are to be advised that VA cannot pay for any portion, including copayments or cost-shares, of their non-VA dialysis care. This discussion must be documented in the veteran’s medical record.

i. All claims for non-VA dialysis treatment received outside of the United States (U.S.) or U.S. territories must be processed through the Foreign Medical Program (FMP) office at the Health Administration Center, Denver, Colorado. Authorization of payment under the FMP is restricted to treatment required for care of service-connected conditions, and veterans participating in a rehabilitation program under 38 U.S.C., Chapter 31 who require care for the reasons enumerated in 38 CFR 17.47(i)(2).

**j. Home Dialysis**

(1) Patients determined suitable for home dialysis treatment by VA staff are provided support services, including: Supplies, ongoing technical and professional assistance, placement, replacement, and installation of dialysis equipment in the patient's home. Support services may be provided directly by VA or through contractual arrangements, when VA has determined such contract to be more cost effective. Authorization for contractual support services must be documented in the Computerized Patient Record System (CPRS) and the Veterans Health Information Systems and Technology Architecture (VistA) Fee Basis Medical Main Menu by appropriate VA staff for subsequent payment processing.

(2) In furnishing needed medical services for the dialysis patient, VA does not encourage the use of paid home dialysis attendants in lieu of VA trained family members. However, under extraordinary circumstances, such as when a family member is not available to assist with dialysis care, use of an appropriate non-VA clinical attendant may be authorized.

## ATTACHMENT B

### CLAIMS PROCESSING OF NON-VA DIALYSIS CARE

#### 1. General Information

a. The responsible Department of Veterans Affairs (VA) physician is to determine which of the two available types of dialysis is to be furnished to the veteran by the non-VA provider. The two types of dialysis are:

- (1) Hemodialysis, and
- (2) Peritoneal Dialysis.

b. Each type of dialysis treatment may generate three bill types:

(1) Facility charges, which are submitted on a Uniform Billing (UB)-04, CMS 1450 billing form, or 837 (I) institutional electronic claims transaction.

(2) Laboratory charges, which are submitted on either a UB- 04/CMS 1450, Centers for Medicare and Medicaid Services (CMS) 1500 billing form, or 837 (P) professional electronic claims transaction.

(3) Physician charges, which are submitted on a CMS 1500 billing form or 837 (P) professional electronic claims transaction. *NOTE: Dialysis claims may be received through Electronic Data Interchange (EDI) and must follow the same process as a paper claim.*

#### 2. Facility Charges

a. **Hemodialysis.** Facility charges for hemodialysis consist of:

- (1) A composite charge for each treatment date.
- (2) Units of medications, as defined by the manufacturer, used during each treatment date.
- (3) Laboratory services charges, if provided in the facility rendering each treatment date.

b. **Peritoneal.** Facility charges for Peritoneal Dialysis provided in the home consist of:

- (1) Daily rental charge for the equipment used in treatment date.
- (2) Units of medications used during each treatment date.

c. **Medications used at Home.** Facility charges for the medications used in the dialysis facility or home setting consist of:

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- (1) The name of the medication used for each treatment date.
- (2) The units of medication as defined by the manufacturer used for each treatment date.

(3) Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes related to the medication used, if appropriate. **NOTE:** *Any items billed such as needles, syringes, administration of injections, etc. are considered as part of the facility charges for the composite treatment and are not payable over and above the billed composite rate.*

### d. Payment of Facility Services (Composite Rate)

(1) Fee Dialysis Care. When VA provides an authorization for non-VA dialysis care, VA must pay the non-VA provider in accordance with Title 38 Code of Federal Regulation (CFR) 17.56.

(2) Contract or Negotiated Dialysis Care. When VA furnishes dialysis care by contract, VA must pay the facility charges according to the terms of the contract or negotiated agreement.

### e. Repricing Agent

(1) Unless a waiver request has been approved, Fee Dialysis claims must be forwarded to the Repricing Agent prior to completion of assignment of payment, except when a contract or negotiated agreement exists. **NOTE:** *Contact the National Preferred Pricing Point of Contact at the VHA Chief Business Office National Fee Program Office at 720-889-2349 for information on re-pricing waivers.*

#### (2) Use of Facility Coding

(a) Composite Treatments. There are no CPT or HCPCS codes for the facility charges.

(b) CPT and HCPCS codes are used to identify the professional services related to medical care provided to a patient.

(c) Because CPT and HCPCS codes do not identify facility charges, providers must use CPT codes to identify their charges.

### f. Codes Used for Reimbursement

(1) The Medicare required CPT code must be used to reimburse for the composite treatment through Medicare.

(2) Any valid CPT code that reflects the dialysis services provided can be used in addition to CPT code 90999 to reimburse the composite treatment through VA. **NOTE:** *All facility charges on the UB-04/CMS 1450 must be identified by revenue code 821.*

### **3. Laboratory Services**

a. Even when dialysis is provided by a non-VA provider, routine laboratory services can be provided as part of the non-VA dialysis care or else furnished in a VA facility. This determination is to be made by the responsible VA Physician. *NOTE: When routine laboratory tests are performed by VA, the test results must be made available to the non-VA provider in a clinically appropriate time frame.*

b. Claims for payment of laboratory services performed in the non-VA dialysis facility are submitted on a monthly basis with the claims for payment of dialysis treatment.

c. Laboratory services provided outside the non-VA dialysis facility in a laboratory setting are to be billed on a CMS 1500 billing form or 837 (P) professional electronic health care claims transaction.

#### d. Payment of Laboratory Services

(1) Fee Dialysis Care. When VA furnishes related laboratory services by an individual authorization, VA must pay the laboratory service charges in accordance with 38 CFR 17.56.

(2) Contract or Negotiated Dialysis Care. When VA furnishes related laboratory services under a contract, VA must pay the laboratory services according to the terms of the contract.

e. Codes Used for Reimbursement. Use of appropriate CPT or HCPCS codes, modifiers and units of service are required to process reimbursement of non-VA dialysis laboratory services.

### **4. Physician Services**

a. Physician charges for dialysis treatments generally consist of the monthly management of the treatments and ongoing case management of the veteran's condition.

b. Physician services provided in relation to the non-VA facility dialysis treatments are to be billed on a CMS 1500 billing form or 837(P) professional electronic health care claim transaction.

#### c. Payment of Physician Services

(1) When VA furnishes physician services by an individual authorization, VA will pay the physician charges in accordance with 38 CFR 17.56.

(2) When VA furnishes physician services through a contract or negotiated agreement, VA must pay for those services according to the terms of the contract or negotiated agreement.

d. Codes Used for Reimbursement. Use of appropriate CPT or HCPCS codes, modifiers and units of service are required to process reimbursement of non-VA dialysis physician services.