Policy: MP069
Section: Medical Benefit Policy
Subject: Ultrafiltration

I. Policy: Ultrafiltration

II. Purpose/Objective:
To provide a policy of coverage regarding Ultrafiltration

III. Responsibility:
A. Medical Directors
B. Medical Management Department

IV. Required Definitions
1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions
Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:
a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards of good medical treatment practiced by the general medical community;
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment
Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:
(i) the service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
(ii) the service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.
(iii) the service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.
DESCRIPTION:
Ultrafiltration therapy, also known as aquapheresis, is a method of removing excess plasma water as a treatment of decompensated heart failure. Blood is withdrawn and returned via the peripheral veins using a peristaltic pump. The blood passes through a filter that allows filtration of water and solutes of less than 50,000 daltons. This allows for rapid fluid removal while maintaining the electrolyte composition of the blood, maintaining heart rate and blood pressure.

FOR MEDICARE and MEDICAID BUSINESS SEGMENT:
In compliance with the CMS local intermediary coverage position, members enrolled under the Medicare and Medicaid business segment may be eligible for coverage of ultrafiltration when the following criteria are met:

The member exhibits signs and symptoms of fluid overload as evidenced by a minimum of three of the following:
- Physical findings of fluid overload such as, significant peripheral edema, trunkal edema, acities, or jugular venous distention;
- Moderately severe dyspnea;
- 8% above dry weight;
- Elevated B-Natriuritic Peptide (BNP) supportive of CHF or radiographic evidence of CHF

AND

Are judged by the provider to have an inadequate diuretic response in the setting of volume overload as evidenced by one of the following:
- Optimal loop diuretic dose;
- Concurrent use of two or more moderately dosed diuretic classes
- Two or more hospitalizations in a 6 month time period
- Rehospitalization for fluid overload within 30 days

EXCLUSIONS: The Plan does NOT provide coverage for Ultrafiltration therapy unless mandated by state or federal regulation because it is considered experimental, investigational or unproven. The Geisinger Technology Assessment Committee evaluated this technology and concluded that there is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this test on health outcomes when compared to established tests or technologies.

Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.

CODING ASSOCIATED WITH: Ultrafiltration
The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at www.cms.gov or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.

CPT Codes:
90945 dialysis procedure other than hemodialysis with single physician evaluation
90947 dialysis procedure other than hemodialysis requiring repeated physician evaluations, with or without substantial revision of dialysis prescription
99356 prolonged physician service in the inpatient setting, requiring direct patient contact beyond the usual service; first hour
99357 each additional 30 minutes
37799
90999


LINE OF BUSINESS:
Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD’s and NCD’s will supersede this policy. For PA Medicaid Business segment, this policy applies as written.
REFERENCES:

Geisinger Clinic Technology Assessment Committee, “Ultrafiltration”, March 2010


This policy will be revised as necessary and reviewed no less than annually.

Devised: 2/03
Revised: 2/04, 2/06; 2/07; 2/08 (wording); 2/10 (Keywords), 9/11 (added Medicare coverage); 9/16
Reviewed: 2/05, 2/09, 2/11, 9/12, 9/13, 9/14, 9/15, 8/17, 8/18, 8/19