

# Dialysis Services

**Policy Number:** BIP045.L  
**Effective Date:** January 1, 2024

[Instructions for Use](#)

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Related Benefit Interpretation Policies
<ul style="list-style-type: none"> <li><a href="#">Ambulance Transportation</a></li> <li><a href="#">Emergency and Urgent Services</a></li> </ul>
Related Medical Management Guideline
<ul style="list-style-type: none"> <li><a href="#">Home Hemodialysis</a></li> </ul>

## Federal/State Mandated Regulations

None

## State Market Plan Enhancements

### Oregon, Washington, and Oklahoma

Routine dialysis care for member’s traveling outside of the service area is subject to approval by UnitedHealthcare or the member’s participating medical group.

### Texas

Routine dialysis care for member’s traveling outside of the service area with the exception of emergency and urgently needed services is subject to approval by UnitedHealthcare or the member’s participating medical group.

## Covered Benefits

**Important Note:** Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/benefits not listed in this section.

Acute/sudden and chronic long term dialysis (peritoneal or hemodialysis) must be authorized by the member’s participating network medical group or UnitedHealthcare and provided within the member’s participating network medical group. The fact that the member is outside the geographic area served by the participating medical group will not entitle the member to coverage for maintenance of chronic long term dialysis to facilitate travel.

**Notes:**

- For dialysis in the home, refer to the Medical Management Guideline titled [Home Hemodialysis](#).
- For chronic/long term hemodialysis, application for Medicare Part A and Part B coverage must be made.
- Benefits are limited to the standard item or equipment or supplies that adequately meet the member’s medical needs

## Not Covered

- Travel dialysis, unless covered in the *State Market Plan Enhancements* section
- Non-emergent out-of-area dialysis services, unless mandated in in the *State Market Plan Enhancements* section

## Policy History/Revision Information

Date	State(s) Affected	Summary of Changes
01/01/2024	All	<ul style="list-style-type: none"><li>• Routine review; no change to benefit coverage guidelines</li><li>• Archived previous policy version BIP045.K</li></ul>

## Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.