Recognize Excellence in Nephrology Practice

The RPA Recognition Awards Program provides an opportunity to recognize the expertise and contributions of nephrologists, practice managers, and nephrology practices. RPA will formally recognize and thank those individuals and practices who are selected to receive the awards during the 2022 RPA Annual Meeting in March.

All members should consider submitting nominations for the following awards:


- **Distinguished Practice Manager Award**—recognizes an individual RPA member who has an active role in managing a nephrology practice for three years or more who exemplifies RPA’s missions, goals, and objectives and has demonstrated professionalism and competence in nephrology practice management in one or more of the following:

RPA QAPI MOC Credit Earning Opportunity Returns for 2021

RPA recognizes that nephrologists are still facing challenges and disruptions in 2021 and that your time is limited. Therefore, we are pleased to offer all nephrologists who participate in Quality Assessment and Performance Improvement (QAPI) meetings at their dialysis facility the opportunity to claim 20 Maintenance of Certification (MOC) credits for the work they are already doing.

As in years past, the RPA QAPI MOC Program allows nephrologists to claim MOC credits for the QAPI meetings they attended in 2021. The RPA QAPI MOC Program recognizes an individual RPA member who exemplifies RPA’s mission and goals and has demonstrated leadership in nephrology practice management in one or more of the following:

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areas: leadership, innovation, staff motivation and communication, business/financial management, patient relations, process improvement, and practice efficiency. Previous years’ recipients include Sharon Rynn, Associates in Nephrology, Chicago, IL (2012); David Doane, Dallas Nephrology Associates, Dallas, TX (2013); Tammy Conger, Knoxville Kidney Center, Knoxville, TN (2014); Susan Przybyla, Mid-Atlantic Nephrology Associates, Baltimore, MD (2015); Beth Shaw, Renal Care Associates, Peoria, IL (2016); Beth Irwin, Colorado Kidney Care, Denver, CO (2017); Annette Wounded Arrows, Renal Care Associates, Peoria, IL (2018); Jennifer Huneycutt, Metrolina Nephrology Associates, Charlotte, NC (2021).

Exemplary Practice Award—recognizes a nephrology practice that is uniquely incorporating and supporting suggested practices and strategic efforts of the RPA while meeting the needs of its community. Previous years’ recipients were Denver Nephrology, Denver, CO (2005); Associates in Nephrology, Chicago, IL (2006); Scott and White Clinic, Temple, TX (2007) and Arizona Kidney Disease and Hypertension Center, Phoenix, AZ (2007); Nephrology Associates of Newark, DE (2008); Kidney Associates of Kansas City, Kansas City, MO (2009); Boise Kidney and Hypertension Institute, Boise, ID (2010); Knoxville Kidney Center, Knoxville, TN (2011); Macon Medical Group, Macon, GA (2012); Kidney Associates, Houston, TX (2013); Balboa Nephrology Medical Group, San Diego, CA (2014); Valley Kidney Specialists, Allentown, PA (2015); Nephrology Associates of Northern Illinois/Indiana (NANI), Oak Brook, IL (2016); Renal and Transplant Associates of New England, Springfield, MA (2017); Nephrology Associates Nashville, Nashville, TN (2019); and Mid-Atlantic Nephrology Associates, Baltimore, MD (2020).

A detailed description of each of the awards along with criteria and nomination forms are posted at https://renalmd.site-ym.com/page/RecAwards. All nominations must be received in the RPA office by January 7, 2022.
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tive. Where would nephrologists turn if RPA didn’t exist? Which organization would represent nephrology’s interests at the American Medical Association House of Delegates, fight for a reasonable portion of the pie when the Relative Value Update Committee discusses payment for specialty-specific procedure codes, or develop reasonable rationales for new CPT codes to reflect innovative new treatments? Further, who would work with the Centers for Disease Control to ensure that the ICD-10 diagnosis codes accurately reflect kidney-related diagnoses?

RPA has a unique niche in the public policy landscape. Over its nearly 50-year history, RPA has developed expertise in regulatory and legislative issues affecting nephrology practice. We have built strong and valuable relationships within CMS, CMMI, the Department of Health and Human Services, and the Centers for Disease Control and Prevention, and with staff on Capitol Hill. We are the go-to organization that is a resource to these agencies when information about nephrology practice is needed.

When the Physician-Focused Payment Model Technical Advisory Committee (PTAC) was seeking to promote specialty-specific payment models, RPA’s proposed model for an Incident ESRD Clinical Episode Payment Model was the only proposed model, across all specialties and disciplines, to be recommended by PTAC for implementation (as opposed to a recommendation for review) by CMMI. As a result, downstream, when CMMI was developing the mandatory and voluntary kidney payment models, RPA leaders and staff were in frequent communication with the CMMI team to provide important insights about how kidney care works in the real world. RPA’s original PTAC proposal included a substantial bonus for successful and lasting kidney transplants, and that policy provision was the precursor to the transplant bonus included in the voluntary payment models.

As part of the 2020 Medicare fee schedule rulemaking cycle, CMS solicited input on families of service codes that were based on evaluation and management (E&M) codes but which had not been increased proportionately with the E&M code revaluations over the previous 15-year period. The inquiry applied to the outpatient dialysis code family of services (i.e., the MCP). RPA was ready with the history of the valuation of the MCP, how it had petitioned CMS over the years to increase the outpatient dialysis code values based on increases in the underlying E&M codes, and why the MCP code values should be increased based on CMS’ solicitation. These efforts bore fruit in the rulemaking for the 2021 fee schedule when CMS finalized valuation increases for virtually all of the outpatient dialysis code values (i.e., the MCP).

On a daily basis, where would nephrology practices get information on renal-specific billing and coding issues, and who would they turn to when their local Medicare Administrative Contractor (MAC) or private insurers rejected claims based on misinterpretations of Medicare or CPT policy? RPA’s billing and coding seminars, and the ongoing availability of RPA coding experts to answer questions about the arcane aspects of billing and coding for services typically provided to kidney patients, typify resources and services that wouldn’t otherwise be accessible in the non-profit world.

RPA shapes federal legislative and regulatory policy in a way that will be favorable to nephrology practice. Further, when policies affecting kidney care are developed, RPA keeps you apprised of any meaningful changes to regulations and legislation impacting your practice and your patients. In addition, RPA provides you with resources to help you comply with these changes and thrive. If RPA didn’t exist, the challenges to maintaining a viable and successful nephrology practice would be much more daunting.

But RPA exists because of the support from nephrologists and practice administrators like you who are reading this column. Your membership dues help cover the costs of the products and services we provide. We greatly appreciate those 107 single invoice practices who have made the commitment for all of their physicians and non-physician employees to join RPA. It is incumbent upon each of you to spread the word about the value of RPA. As we are in the midst of dues renewal season for 2022, now is the time to step up and support the only professional membership association that represents the needs of practicing nephrologists around the country.

Physician dues are $425 for the year. Note that the median 4-visit MCP payment for one patient for 2021 is $363 and, as noted above, that was a significant increase over the previous year, due to the advocacy work of RPA. Now more than ever, please encourage your colleagues in your practices and in your communities to become engaged with the RPA so we have the resources needed to continue to do the important and essential work on behalf of the nephrology specialty. Let’s not wonder what would happen to nephrology payment if RPA ceased to exist or who you would turn to for help with your MAC. Let’s do everything in our power to ensure that RPA thrives into the next decade and beyond. Thank you in advance for your continued support.

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This content is adapted from a presentation given at RPA’s 2021 Physician Leadership Conference. For more information, contact Dale Singer, MHA, RPA Executive Director, at dsinger@renalmd.org. Future presentations will be available on the RPA website at www.renalmd.org.
RPA QAPI MOC Credit Earning Opportunity Returns for 2021

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organizations who take part in at least 5 QAPI meetings in a 6-month period during 2021 are eligible for the program. The following dialysis organizations are participating in the 2021 program:

- American Renal Associates
- Atlantic Dialysis Management Services
- Berkshire Medical Center
- Branson Dialysis/Harrison Dialysis
- Centers for Dialysis Care
- Chattanooga Kidney Centers
- DaVita, Inc.
- DCI
- Dialyze Direct
- Fresenius Kidney Care
- Greenfield Health Systems
- The Kidney Center
- Kidney Center Home Therapies
- Laurel Canyon Dialysis/Santa Clarita Dialysis/
  Northridge Kidney Center
- Lewisburg Dialysis Clinic
- Lock Haven Dialysis Clinic
- Loyola Center for Dialysis
- Physicians Dialysis
- Satellite Healthcare
- Sanderling Renal Services-USA
- U.S. Renal Care
- University of Virginia
- Williamsport Dialysis Clinic

Nephrologists affiliated with any of the organizations above may register and view detailed instructions at www.renalmd.org/RPAQAPIMOCProgram. The RPA QAPI MOC Program fee is $50 per physician per year, paid by the participating nephrologist. RPA membership is not required to participate.

Should you need to reset your password for the RPA QAPI MOC Program, please contact the help desk at MedconcertSupport@premierinc.com. RPA does not have access to this password.

For more insights on the nephrologist’s role in the CfCs, download the RPA’s 2020 position paper on Responsibilities Under the Revised CMS Conditions for Coverage for End-Stage Renal Disease Facilities from the RPA Store at https://rpa.users.membersuite.com/shop/store/0ad80326-00ce-c558-d948-17e054455881/detail. 

Public Policy News Briefs

- RPA Comments on 2022 Payment Rules—On August 31, RPA submitted comments to CMS on the proposed rule for the 2022 ESRD Prospective Payment System (PPS), which included revisions to the ETC mandatory payment model. On the ETC proposals, RPA supported CMS’ plans to expand access to kidney disease education (KDE) services and to make transplant waitlist data available to nephrology managing clinicians. Other issues addressed in the comments included calling on CMS to create a QIP exclusion for palliative dialysis patients, and enhancement of the pediatric ESRD PPS bundle.

  On September 13, RPA submitted comments to CMS on the proposed rule for the 2022 Medicare Fee Schedule. RPA recommended CMS withdraw its proposal to revise the clinical labor pricing inputs as well as to not implement the definition of ‘substantive portion’ within the proposal to update policy on split/shared visits. RPA also submitted comments on the 2022 Hospital Outpatient Prospective Payment System/Ambulatory Surgical Center (HOPPS/ASC) proposed rule that addressed CMS’ proposals on the inpatient-only code list and device-intensive code status. RPA’s comments are posted at www.renalmd.org. All the payment policy final rules for 2022 are expected to be published this month.

- RPA Urges CMS to Not Finalize Proposed Clinical Labor Policies in Coalition Letter—Separately on the payment fee schedule, on September 7, RPA joined a group of 16 health and medical organizations in calling on CMS to not finalize proposed revisions to clinical labor pricing in the 2022 Medicare Fee Schedule. These revisions combined with the budget neutrality requirement in the Medicare Fee Schedule would result in cuts for key dialysis access services of 15% or more in 2022. The letter also notes the potential of the policies to exacerbate health care disparities and to further weaken the health care delivery system’s ability to deal with the COVID-19 pandemic.

- CMS Approves New Code for Innovative Placement of Central Venous Catheters—On September 16, CMS published a transmittal updating the Healthcare Common Procedure Coding System (HCPCS) within the Hospital Outpatient Prospective Payment System (OPPS) by adding a new HCPCS code (C9780) for insertion of a central venous catheter through central venous occlusion via an inside-out technique. This code expands the options available to interventional nephrologists and other vascular access specialists by helping to decrease venous obstructions. RPA advocated for coverage of the new code in a letter to CMS in August 2020. HCPCS code C9780 was effective October 1, 2021.

- CMS Administrator Offers Vision of CMMI, Alternative Payment Models—On August 12, CMS Administrator Chiquita Brooks-LaSure and CMMI Director Elizabeth Fowler and other senior CMMI staff offered a review of how CMMI has fared over its first ten years of existence and their vision on the future of CMMI and alternative payment models in a blog post on the Health Affairs website. Among the lessons learned were: (1) that equity needs to be at the center of future models; (2) offering too many models is overly complex, particularly when models overlap; (3) a reevaluation of designs for financial incentives in CMS models to ensure meaningful provider participation is necessary; (4) challenges in setting financial benchmarks have undermined CMMI models’ effectiveness; and (5) defining success as encouraging lasting transformation rather than focusing solely on each model’s cost and quality improvements, is a likely path for the future. The blog post also notes CMMI’s commitment to providing greater accessibility and transparency in sharing Innovation Center data and receiving more input on CMMI proposals from patient and community stakeholders.

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Democrats themselves as Senators Joe Manchin (D-WV) and Kyrsten Sinema (D-AZ) are resistant to a really big-ticket package moving forward (since either way this will be a big-ticket package). House moderates led by Rep. Josh Gottheimer (D-NJ) have demonstrated previously unseen backbone in aligning with Senators Manchin and Sinema. House leaders led by Rep. Pramila Jayapal (D-WA) with support from Senator Bernie Sanders (I-VT) are making the case that the $3.5 trillion dollar funding level was itself a compromise from a previously sought $6 trillion or so level. They are concerned that coming down to say $2 trillion or so (this is thought to be the approximate number in play now) will eliminate or vastly reduce spending on vital social programs and efforts to address climate change, among other worthy considerations.

So, at the risk of contributing to the horse-race media’s favorite narrative of “Dems in Disarray,” the Dems are at least somewhat in disarray, with Speaker Pelosi’s magic powers being challenged more than ever before. Now, in fairness, the Democrats would respond that developing, refining, and enacting social benefit legislation of this scope and magnitude is always a time consuming and complex process (witness the Affordable Care Act, which took months to come to fruition) and that was exactly what was expected. So, for all of this is the normal process of negotiation. However, it was Democratic leadership at both ends of Pennsylvania Avenue who raised the expectation of passage before September 30, and all of this is occurring in the shadow of the more urgent need to address the nation’s debt ceiling (discussed in detail in the September issue of RPA News).

Regarding health policy issues in the reconciliation bill, it is interesting that the provision that would add dental and vision coverage to Medicare is in fact opposed by the organized dental community. This is because the ability to continue to balance the bill for the services and to not be Medicare regulated looks pretty good to them, although it is noteworthy that back in the 1960’s organized medicine opposed the creation of Medicare, a position they likely wouldn’t take today. Another broad issue being discussed in the context of the reconciliation efforts is whether to mean test some of the changes proposed for Medicare (means-testing being a vehicle to limit services or benefits to individuals who don’t have the means to provide it for themselves). Senator Manchin is a big proponent of means-testing many of the proposed benefits, and this would substantially lower the price tag for the bill, while progressives like Senator Sanders and House Appropriations Committee Chair Rosa DeLauro (D-CT) would argue that this is inherently unfair to those barely on the wrong side of the threshold for the means test and that one of the strengths of the Medicare program is its universal availability to all seniors in the U.S. It is not a leak to forecast that the desire for a lower price tag for the Build Back Better bill would likely decrease the odds of dental and vision benefits being added to Medicare, and means-testing being given serious consideration.

Shifting away from reconciliation and the macro issues, necessary Congressional action on scheduled cuts in physician reimbursement for 2022 is occupying most of organized medicine’s attention (of course, this seems pretty macro to us). Recall that the 2021 resolution of these issues ended about as well as could have been hoped for, especially for nephrology and primary care, but really across the board as well. What was proposed for 2021 was an across the board approximate 10% pay cut; this was limited to a 3.75% reduction in the conversion factor, the 9-10% across the board Medicare 99251 code was eliminated for 2022. Additionally, two additional reductions in the form of the sunsetting of the 2% Medicare sequestration cut and a 4% ‘PAYGO’ hit (essentially a budget neutrality policy device) would bring the total reduction in physician reimbursement to a figure of 9-10% for 2022. Now, few people in Washington think this is going to happen, but Congress is going to have to act to make this so. Toward this end, Rep. Larry Bucshon, M.D. (R-IN, Chair of the Congressional Kidney Caucus and honoree at RPA’s early summer PAC reception) and Ami Bera, M.D. (D-CA, and an internist) have generated a ‘Dear Colleague’ letter to Congressional leadership supported by 135 specialty societies and medical organizations across the nation (and 8 state medical societies, and cosigned by 246 other members of the House. In fact, if cosigning this letter is an indication of momentum, the number of Congressional offices almost doubled within a week in early October, so that’s positive. Efforts on the part of the RPA, the AMA, and all of organized medicine to obtain relief from the proposed cuts will continue throughout the fall and early winter if necessary. Another issue that cuts across all specialties is how Capitol Hill will deal with telehealth. While the current flexibilities provided by the public health emergency (PHE) are not expected to end anytime soon (they are definitely in place until mid-December, and most observers believe the PHE won’t end until mid-year 2022 at the latest) permanent change must be legislatively mandated by Congress. There is no lack of proposed bills out there to extend the flexibilities, with the highest profile legislation being the CONNECT for Health Act of 2021 (S. 1512/H.R. 2903—the acronym stands for “Creating Opportunities Now for Necessary and Effective Care Technologies.” RPA is an endorsing organization of the CONNECT Act, and one of the reasons for this is that it does not include a provision that would eliminate the quarterly face-to-face requirement for home dialysis patients. While this is not an issue during the PHE as all nephrologist-MCP patient interactions can occur via telehealth, for now, RPA strongly believes that post-PHE, physicians and patients should see each other quarterly, and several of the telehealth bills do include a provision to remove the requirement. Political intelligence on the issue secured by RPA indicates this provision does not have much support among Congressional offices, but our staff is closely monitoring the situation. More broadly, the telehealth legislation may be suffering from its own popularity, in that there is so much bipartisan support for big provisions like eliminating the originating site and geographic restrictions that some legislators believe it is best to let it remain in place, and amend the PHE to keep it in place, while the PHE still in place, the urgency is not profound. While this is a good problem to have, there will likely be a time when nephrology and organized medicine have to move swiftly to make sure the bill is enacted.

On legislation specific to kidney care, there has been no lack of activity. The Living Donor Protection Act (S. 377/H.R. 1255) currently has 32 cosponsors in the Senate and 87 in the House, and despite some sausage-making drama earlier in the year with regard to very granular language revisions, there doesn’t seem to be any real opposition to the bill, with the challenge as always being finding a legislative vehicle to which it can be attached, and the Congressional Budget Office (CBO) agreeing with expectations that it won’t cost very much. Less progress has been made on the Chronic Kidney Disease Improvement in Research & Treatment Act (S.1971/H.R. 4065); the bills have 1 and 6 co-sponsors in each chamber, respectively, but the odds are never very high that that bill will be enacted in toto anyway. Early August saw the introduction for the 117th Congress of the Bringing Enhanced Treatments and Therapies to ESRD Recipients Kidney Care Act (the ‘BETTER’ ACT, S. 2649/H.R. 4942). This is the fairly controversial bill that would create ESRD payment models that would place much of the control of the models in the hands of dialysis organizations. RPA did support a previous iteration of this bill prior to the advent of the PHE kidney payment models but opted not to support a subsequent, post-kidney payment model version. Additionally, on September 29, legislation to provide coverage for staff-assisted home dialysis was introduced in the House (H.R. 5426); at press time the bill did not have a concise title and there are currently the two original sponsors, Rep. Bobby Rush—D-IL, and Jason Smith, R-MO. This is certainly in keeping with commendable efforts in recent years to promote home dialysis in the U.S., but as with many proposals of this nature, there are many squishy details to be resolved before it progresses. The RPA Government Affairs Committee will be considering the status and merits of all of the kidney proposals currently being advanced on the Hill.

So, despite the toxicity on Capitol Hill, in many ways, this year is not unlike many we’ve experienced in recent times. Massive, somewhat existential bills must be resolved before Congress moves on to issues that seem closer to home, some big legislative vehicle will have to move between Thanksgiving and the end of the year to address telehealth. While the current flexibilities provided by the public health emergency (PHE) are not expected to end anytime soon (they are definitely in place until mid-December, and most observers believe the PHE won’t end until mid-year 2022 at the latest) permanent change must be legislatively mandated by Congress. There is no lack of proposed bills out there to extend the flexibilities, with the highest profile legislation being the CONNECT for Health Act of 2021 (S. 1512/H.R. 2903—the acronym stands for “Creating Opportunities Now for Necessary and Effective Care Technologies.” RPA is an endorsing organization of the CONNECT Act, and one of the reasons for this is that it does not include a provision that would eliminate the quarterly face-to-face requirement for home dialysis patients. While this is not an issue during the PHE as all nephrologist-MCP patient interactions can occur via telehealth, for now, RPA strongly believes that post-PHE, physicians and patients should see each other quarterly, and several of the telehealth bills do include a provision to remove the requirement. Political intelligence on the issue secured by RPA indicates this provision does not have much support among Congressional offices, but our staff is closely monitoring the situation. More broadly, the telehealth legislation may be suffering from its own popularity, in that there is so much bipartisan support for big provisions like eliminating the originating site and geographic restrictions that some legislators believe it is best to let it remain in place, and amend the PHE to keep it in place, while the PHE still in place, the urgency is not profound. While this is a good problem to have, there will likely be a time when nephrology and organized medicine have to move swiftly to make sure the bill is enacted.
Evolving Legislative Timelines Underscore Importance of RPA PAC

One of the benefits (and curses) of aging is that one remembers how things used to be way back when. For legislative analysts of a certain vintage, this means recalling when appropriations bills would be developed in the spring, refined and finalized in summer, with no threat of funding not being in place for the October 1 start of the next fiscal year. This applied to authorizing bills as well, with there being little question whether legislation in broad content areas such as child welfare, health care, and national security would progress and be enacted. This predictability generally meant Congress could all but shut its doors for the months of August and December, since it was able to get all of its work done in the other 10 months.

Ah, the good old days. Anybody reading this column knows that this is not the case anymore, with legislating being a year-round activity and some of the most consequential bills in recent decades being enacted in the second half of December. 2021 looks to be no different. At press time, long-term government funding, the debt ceiling, the bipartisan infrastructure bill, and the Medicare Administration human infrastructure legislation all have yet to be resolved. And given that the aircraft-carrier-sized bills are still consuming all of the oxygen on Capitol Hill, legislation on issues important to nephrology and organized medicine such as physician reimbursement, telehealth, and anything having to do with the kidney will be on the table during the holiday season.

Fortunately, the RPA Political Action Committee (RPA PAC) is on the case to make sure nephrology is represented when these issues are hashed out in Congress. Late summer and fall saw RPA PAC support Reps. Lisa Blunt Rochester (D-DE, member of the House Energy and Commerce Health Subcommittee and rising star in the Democratic Party), Cathy McMorris Rodgers (R-WA, and ranking member of the House Appropriations Committee and ardent kidney care advocate), Raul Ruiz, M.D. (D-CA, and member of the E&C Health Subcommittee) and Bobby Rush (D-IL, E&C Committee member and staunch advocate for equitable vascular access reimbursement). In the Senate, the PAC participated in an event for Senator Ron Wyden (D-OR, and Senate Finance Committee Chair).

Highlights of these events included: (1) Rep. McMorris Rodgers expressing optimism about working with E&C Chair Frank Pallone (D-NJ) on physician reimbursement; (2) Rep. Herrera Beutler analyzing in real-time the Democrats efforts on budget reconciliation/’Build Back Better,’ interestingly noting her interpretation that when Republicans do big bills, leadership tells them they can have nothing, and gradually adds provisions to the bills, while Democrats start big and have to have provisions removed; and (3) Senator Wyden showing deep interest in vaccinations in dialysis facilities, kidney disease education, and telehealth in kidney care. RPA attendees raised the importance of addressing proposed Medicare pay cuts, living organ donation, and eliminating originating site and geographic restrictions in any telehealth legislation moving forward.

There are big issues for nephrologists and all physicians getting addressed and resolved (hopefully positively) in the coming weeks and months, and it is of the utmost importance that nephrology is actively involved in these discussions. Recall that the insurance industry, health systems, dialysis companies, the legal profession, and most other physician specialties have PACs and are meeting with legislators via this avenue. RPA PAC is the only organization participating in this discourse that is specifically there on behalf of nephrologists.

Please help enhance RPA’s ability to engage with policymakers as described above by donating to the RPA PAC today at https://rpa.users.membersuite.com/auth/portal-login or send a personal check to RPA PAC, 1700 Rockville Pike, Suite 320, Rockville, MD 20852. If you have any questions, please contact RPA’s Director of Public Policy Rob Blaser at 301-468-3515, or at rblaser@renalmd.org or morgler@renalmd.org.

RPA PAC is a separate, segregated fund established by RPA. Voluntary contributions by individuals to RPA PAC will be used to support candidates for public office regardless of political affiliation who demonstrate their belief in the principles to which the profession of nephrology is dedicated. Contributions from corporations and associations as well as medical practices are prohibited by federal law and cannot be accepted. Contributions to the RPA PAC are not deductible as charitable contributions for federal income tax purposes.

RPA Recognizes Corporate Patrons

The RPA corporate patrons program is designed to augment the alliance between stakeholder industries and the RPA, since corporate members of the nephrology community play an important role in optimizing patient outcomes. Gifts from corporate patrons are for scientific or educational purposes. During the year RPA leaders meet with representatives from corporate patrons participating companies to discuss areas of mutual concern and interest. This informal dialogue benefits industry and the association.

Potential donors should contact the RPA office to obtain additional information. Links to all of our corporate patrons’ sites may be found at www.renalmd.org.

RPA is pleased to acknowledge the support provided by all of our corporate patrons in this issue of RPA News.
With the increase in regulations today and the ever-changing coding and billing rules, it can be daunting to stay abreast of all of the guidelines for CPT, E&M, and ICD-10 coding (Leathers and Provenzano, 2017). The reimbursement side of medicine is filled with the potential for a denial for every claim submitted due to rules changing frequently and each payer having its own policies. 2021 brought new office/outpatient coding and documentation guidelines with the relaxation of documentation of history and exam and the focus on medical decision making and/or time. As we approach a new year, there have been a large number of proposed changes for 2022 that will again alter the way physicians and non-physician practitioners bill for various services in the office and/or hospital setting if they are approved. Telehealth coding and billing guidelines have some proposed changes for 2022, and CMS has proposed to retain all services added to the Medicare telehealth service list until the end of 2023, to allow more time to collect data (Joy, 2021). CMS has proposed that the home of the beneficiary would qualify as an originating site (Joy, 2021). One of CMS’ proposed changes would be a modification of the existing policies is for split/shared services. This modification, if approved, will allow physicians and non-physician practitioners to bill for initial and subsequent care along with critical care and certain visits in the skilled nursing facility (SNF) (Joy, 2021).

With all of the changes that have occurred in 2021 regarding office and outpatient coding and the potential coding and documentation changes coming in 2022, it is now a good time to conduct a review of your documentation and coding to ensure that you’re compliant with current guidelines and preparing for changes slated for 2022. With the growing body of regulations today, there is an increase in required specificity and payer requirements, and thus, coding and billing is becoming more complex. Submitting inaccurate claims for payment raises the risk of violating federal health care program laws, which is why it is important that coding and billing are accurate. It is critical to the success of a nephrology practice to accurately submit claims for payment to be accurately reimbursed for services provided. Given changing reimbursement and regulations, as well as the increased scrutiny by Medicare and other payers, a structured coding review is an appropriate process improvement measure for nephrology practices and may minimize a practice’s audit risk. CMS and the Office of Inspector General (OIG) recommend that providers routinely audit coding (Chapman, 2018). The following are key steps to consider when looking to implement a coding/billing audit, either internally or from an external source.

**Key Steps to a Coding/Billing Audit:**
1. Identify who will perform the coding audit
   a. internal or external auditing staff (or both)
2. Develop the scope of the coding audit: setting types (inpatient, outpatient, physician office, etc.)
3. Determine the volume of records (number of encounters), making sure the audit size is relevant and the date range is appropriate (by quarter, one specific month, etc.)
   a. Decide whether the audit will be random versus focused (or a combination)
   b. Define a coding variance or error so there are no surprises at the end of the audit
4. Determine the type of coding audit: pre-bill/prospective and/or retrospective (after the claim/bill has been paid)
   a. Ensure that both diagnosis and procedure (both ICD 10 CM/PCS and CPT) codes are audited
5. Secure auditing resources and tools: ICD 10 CM/PCS guidelines, codebooks, CPT codebook, American Medical Association (AMA) CPT Assistant, CMS manual
6. Develop a chart review process
   a. Audit functions while performing the review
   b. How you will document the findings and provide a written explanation
7. Post-audit
   a. Create an audit summary along with recommendations
   b. Conduct education
   c. Implement resolution of coding errors: this includes any rebilling of overpayment (Bradley, 2020)

Due to the complexities of nephrology, and the ever-changing coding and billing guidelines, mistakes in medical practices are common. This is why it is vital for medical practices to establish robust oversight, and audit to ensure accurate coding and billing. Based on past experience, it is clear that the rules and regulations in the world of coding will continue to change, and therefore providers will continue to face increased scrutiny of their coding and documentation. Coding reviews can help nephrologists to assess the accuracy and completeness of their documentation as well as determine if the documentation supports the claims submitted for payment. Coding reviews may minimize your practice’s audit risk, and a structured, ongoing coding review process may also help with your practice’s effective compliance program.

This article is for informational purposes only, and not intended to serve as legal or coding advice. There are additional changes occurring on January 1, 2022 that may impact providers. Each provider should seek guidance from legal counsel or a certified coder to determine how any such changes may impact him or her.

**Suzanne is a coding review manager at Nephrology Practice Solutions by DaVita. She may be reached at suzanne.leathers@davita.com.**

**Works Cited**
On September 9, 2021, President Biden announced a broad national COVID-19 action plan (the Plan) to combat the pandemic at the federal level. The Plan outlines a six-pronged approach, including new obligations for large employers, certain federal contractors and subcontractors, and certain health care providers that receive Medicare or Medicaid reimbursement. The obligations include extensive new vaccination requirements and, in some cases, testing requirements as alternatives. The Plan, entitled “Path out of the Pandemic,” includes the following elements: (i) Vaccinating the Unvaccinated, (ii) Further Protecting the Vaccinated, (iii) Keeping Schools Safely Open, (iv) Increasing Testing & Requiring Masking, (v) Protecting Our Economic Recovery, and (vi) Improving Care for those with COVID-19.

The first prong of the Plan, Vaccinating the Unvaccinated, is particularly significant for nephrologists and nephrology practices. Under its requirements (i) nephrology practices with 100 or more employees will be required to ensure either that their workers are vaccinated or that they undergo weekly testing, and (ii) nephrologists and their staff who provide services to patients at Medicare-certified dialysis facilities will be required to be fully vaccinated, subject to accommodations which may be made for disabilities and/or sincerely held religious beliefs.

Nephrology Practices with 100 or More Employees
To achieve the goal of the first prong of the Plan, President Biden instructed the Department of Labor’s Occupational Safety and Health Administration (OSHA) to develop a rule requiring employers with 100 or more employees to ensure that their workforce is fully vaccinated or require any workers who remain unvaccinated to produce a negative test result on at least a weekly basis before coming to work. The White House announced that OSHA will issue an emergency temporary standard (ETS) to implement this requirement.

This new ETS will supplement the ETS that OSHA adopted on June 21, 2021, entitled Occupational Exposure to COVID–19; Emergency Temporary Standard, 29 C.F.R. Part 1910, Subpart U, 86 Fed. Reg. 32376 (the June ETS). The June ETS was limited to the health care sector. OSHA may issue an ETS if it determines “(A) that employees are exposed to grave danger from exposure to substances or agents determined to be toxic or physically harmful or from new hazards, and (B) that such emergency standard is necessary to protect employees from such danger.” OSHA limited the applicability of the June ETS to the health care sector, due to concerns that the “grave danger” and “necessary” criteria had not been met for a broader application of the ETS in light of the accelerating rate of vaccinations at that time. Through the Plan, President Biden effectively reversed this determination and directed OSHA to adopt a broadly applicable ETS requiring vaccination or testing for all employers with 100 or more employees. In justifying this expansion, the Plan notes that the administration has determined that the danger from unvaccinated workers is “grave” and that mandatory vaccinations are “necessary” to protect all workers from COVID-19.

The issuance of OSHA’s new ETS is expected within weeks following the announcement of the Plan. The new standard will likely take effect shortly after its publication in the Federal Register. The June ETS has some provisions that became mandatory 15 days after publication, while compliance with others was required a month after publication. 29 C.F.R. § 1910.502(m)(2). The new ETS is likely to use the same phased approach in implementing its requirements.

How Should a Practice Calculate the Number of Its Employees?
All nephrology practices with 100 or more employees will be subject to the ETS requirement. Practices should prepare for the forthcoming ETS by counting their employees individually and should include in the count employees that are employed on a full-time or part-time basis. Independent contractors and leased employees are generally not counted towards the number of employees of a particular employer; however, joint-employment stipulations may be addressed in the ETS. Additionally, nephrology practices should consider whether (i) employees are employed by a single legal entity, or separate legal entities, (ii) located at different worksites, or working remotely. Once released, the ETS will likely provide specific detail on whether the 100 or more employee threshold will be determined (i) based on the number of employees, enterprise-wide (ii) based on the number of employees at a particular worksite, or (iii) using a different calculation methodology altogether. Collecting this information in advance of the issuance of the new ETS will ensure that nephrology practices are prepared to respond quickly to the requirements of the new ETS.

Paid Time Off for Vaccination and Possible Side-Effects
The current plan does not address payment or reimbursement for vaccinations and tests. However, pursuant to the announced plan, the new ETS is expected to require employers with 100 or more employees to provide paid time off for the time it takes an employee to receive a vaccine and any time required to recover if an employee becomes ill or experiences side effects post-vaccination. This is akin to the requirement contained in the June ETS, which provides that: “The employer must support COVID-19 vaccination for each employee by providing reasonable time and paid leave (e.g., paid sick leave, administrative leave) to each employee for vaccination and any side effects experienced following vaccination.” 29 C.F.R. § 1910.502(m).

Further, the “hours worked” and overtime rules for non-exempt employees in the Fair Labor Standards Act should still apply, such that time spent on vaccinations, testing, and documentation must be paid.

Exemptions to the ETS Requirements

Legal Issues: President Biden’s COVID-19 Action Plan—Key Considerations for Nephrology Practices
By Kimberly Kannensohn, Meredith Pinson, and Nesko Radovic

3 The new standard will likely take effect shortly after its publication in the Federal Register. The June ETS has some provisions that became mandatory 15 days after publication, while compliance with others was required a month after publication. 29 C.F.R. § 1910.502(m)(2). The new ETS is likely to use the same phased approach in implementing its requirements.
Guidance) to address COVID-19 vaccines in the workplace. EEOC Guidance clarified that the federal equal employment opportunity laws do not prevent an employer from requiring all employees physically entering the workplace to be vaccinated for COVID-19, subject to the reasonable accommodation provisions of Title VII of the Civil Rights Act (Title VII) and the Americans with Disabilities Act (ADA). The ADA and Title VII require an employer to provide reasonable accommodations for employees who, because of a disability or a sincerely held religious belief, practice, or observance, do not get vaccinated for COVID-19, unless providing an accommodation would pose an undue hardship on the operation of the employer’s business. The ETS will likely include additional detail and guidance regarding exceptions that will be available to employees. However, the ADA and its provisions requiring reasonable accommodations for employees with disabilities, as well as Title VII and its provisions requiring accommodations for sincerely held religious beliefs, remain intact under the new forthcoming ETS. Practices should continue to carefully consider the application of the requirements of Title VII, the ADA, and any other state-based equal employment opportunity laws to any request for accommodation they receive from their employees, in consultation with labor and employment counsel.

Penalties for Violations of the New ETS
The Biden Administration announced that violations of the new ETS would subject the violator to penalties of up to $14,000 per offense. This appears to be a rounded reference to the current OSHA maximum fine for serious non-willful/non-repeated citations, which is $13,653 per violation. (29 C.F.R. § 1903.15(b), 86 Fed. Reg. 2964, Jan. 14, 2021). However, if OSHA concluded that a violation was in fact willful, or if an employer had a repeat of the same violation in a short period of time, then, under OSHA’s penalty scheme, OSHA could issue fines well into the six figures.

Provision of Services at Medicare-certified Facilities
The Plan’s first prong builds on the vaccination requirement for nursing facilities announced by CMS on August 18, 2021, and will apply to nursing home staff as well as health care workers in hospitals, dialysis facilities, and other CMS-regulated settings, including clinical staff, individuals providing services under arrangements, volunteers, and staff who are not involved in direct patient, resident, or client care. Specifically, CMS stated in its September 9, 2021 press release that the emergency regulations requiring vaccinations will include hospitals, dialysis facilities, ambulatory surgical settings, and home health agencies, among others, as a condition for participating in the Medicare and Medicaid programs. CMS is developing an Interim Final Rule with

Enrich Your Leadership Experience: Nominations are Open for Service on RPA Board of Directors

Do you want to help chart the course for the future of your specialty? Do you want to influence legislation and regulations affecting nephrology practice and kidney care? Do you want to be part of a dynamic group of leaders from across the country who are committed to maintaining thriving independent nephrology practices? If you answered yes to any of these questions, nominate yourself or ask a colleague to nominate you for service on the RPA Board of Directors. The knowledge and experience gained by serving as a Board member increase your value to your practice and your community. Board members serve a 3-year term beginning in March 2022. Simply complete the nomination form at www.renalmd.org, attach the required CV and submit it by December 6, 2021. Board members are required to attend four 2-day Board meetings per year as well as participate in the annual meeting, Capitol Hill Day, PAL Forum, various committee meetings, and special projects. Nominees should have previous RPA/nephrology leadership volunteer experience. RPA’s future is in your hands! If you would like additional information about this exciting opportunity, feel free to contact RPA’s executive director Ms. Dale Singer at dsinger@renalmd.org or the RPA nominating committee chair and RPA Past President Dr. Jeffrey Perlmutter at rpa@renalmd.org. ©

6 Centers for Medicare and Medicaid Services, Press Release: Biden-Harris Administration to Expand Vaccination Requirements for Health Care Settings (September 9, 2021).
7 Am. Hospital Ass’n, AHA Urges CMS to Ensure Its Mandatory Vaccination Rule is Feasible, Fair (Sept. 27, 2021), available at https://www.aha.org/2021-09-27-aha-urges-cms-ensure-its-mandatory-vaccination-rule-feasible-fair. See also Nathaniel Weixel, Nursing homes warn vaccine mandate could lead to staff shortages, The Hill (Sept. 4, 2021) (advocating for broader implementation to previous SNF-only mandate).
Back to Basics: Nephrology Coding and Billing

By Shaun Conlon, MD

As I pointed out in my previous column, my medical training did a great job preparing me to take care of patients, but not a great job teaching me the business of medicine. This is the second in a series of articles discussing some fundamental topics that more seasoned RPA members take for granted. The first article discussed health insurance. Now let’s talk about coding and billing as it applies to (non-interventional) nephrologists.

Nephrologists generally see patients in three venues – office, hospital, and dialysis facility. Each of these has a separate set of billing and coding guidelines. For all these, we submit claims to insurance companies with CPT (current procedural terminology) and ICD-10-CM (international classification of diseases, 10th edition, clinical modification) codes. The insurance company then pays a specified amount that is related to the RVU (relative value unit) weight of the submitted CPT codes. The RPA designates several of its members to serve on committees that oversee the development of new CPT and ICD-10-CM codes and that determine the RVU weighting of the CPT codes.

In the office setting, the most commonly used codes are those for new and established office patients (99202-99215). Prior to 2021, the documentation guidelines for these codes were similar to the initial and follow-up hospital visit codes. However, starting this year, the documentation requirements for these office codes have been greatly simplified. History and physical examination are no longer part of the determination of code selection (they are still important in communicating with other providers and for liability purposes). The selection of the appropriate code is based either on MDM (medical decision making) or total time spent on the day of the visit (inclusive of preparation to see the patient, time with the patient, and documentation time). Although the MDM table seems complex at first glance, I think it’s important to focus on a few items that many of our patients share. For example, a patient with two stable chronic illnesses (e.g., chronic kidney disease and hypertension) that we treat with prescription medication (e.g., losartan) is moderately complex and should be coded as a 99204 or 99214.

Additionally, nephrologists may use several other code families in the office:

- Chronic care management – these codes are billed monthly and require the nephrologist’s office to develop a care plan for the patient
- TCM – these codes are usually billed after a hospitalization; they involve a review of hospital records and reconciliation of medication changes
- Advanced care planning – these are paid to discuss advanced directives with patients
- Telephone codes – these are usually billed when telehealth is not feasible (as telehealth is billed using the same CPT codes as in-office visits) and based on time

In the hospital setting, the most commonly used codes are the initial and subsequent visit codes (99221-99223 and 99231-99233). Unlike the office visit codes, the hospital codes have requirements for history, physical examination, and medical decision making. As you move up in complexity with these codes, there are increasing requirements for each of the three components. For initial visits, the complexity must be met for all three of the parts of the note. For subsequent visits, the complexity must be met for only two of three parts of the note (keeping in mind that medical decision making should be the primary driver for the complexity of the note). As with the office codes, although the documentation guidelines can seem complex, it helps to think about points that many patients will share. For example, a patient with acute renal failure with a workup planned will generally be high complexity medical decision making.

Several of the other codes used by nephrologists in the hospital setting include:

- Dialysis codes – these are used when we supervise a dialysis treatment (either intermittent or continuous); these require the nephrologist to be present during the procedure and cannot be billed on the same day as a subsequent visit (they can be billed on the same day as an initial visit)
- Critical care codes – these are time-based codes used when providing care to a patient in the ICU setting

The last venue where nephrologists commonly see patients is at the dialysis unit. Unlike office and office billing which is fee-for-service (each service is billed and paid separately), dialysis billing is bundled (one single payment per month of service). The dialysis codes most commonly used are the MCP (monthly capitation payment) codes. There are three MCP codes for in-center hemodialysis patients based on the number of provider visits in the month (1, 2-3, or 4) and one MCP code for home dialysis (both home hemodialysis and peritoneal dialysis) patients. The MCP payment covers all outpatient services for ESRD-related problems within the month. This includes when these problems are addressed in an emergency room or observation setting at a hospital. The major documentation requirement for the MCP is the comprehensive assessment of the patient that must be done once per month. This assessment should touch on the major domains of ESRD care (i.e., adequacy of dialysis, access, volume management, anemia, mineral bone disease). In addition to full month MCP codes, there are also daily visit codes for ESRD patients for circumstances when care is provided for less than a full month.

This article only provides a basic overview of nephrology coding and billing. For a more comprehensive look at this topic, I suggest attending RPA’s coding and billing seminar, updated yearly with the most current rules and regulations.

Dr. Conlon has lived in Atlanta with his wife and family for over a decade. After finishing his residency and fellowship at Emory, he joined Atlanta Nephrology Associates where he is now a partner. Dr. Conlon serves as a member of the RPA Board of Directors.

This is part of a series of articles aimed at “young nephrologists” from Dr. Conlon’s perspective. This column does not represent the views of the RPA.
I have a question about how to bill CPT code 90989 for initial PD training. My coder says that this code cannot be billed because it is not in the Medicare physician fee schedule. I also cannot find information about this on the CMS website.

This code can still be billed. It was taken out of the fee schedule years ago because there are no relative value units (RVUs) assigned to it, but it is still a payable service. In fact, it is a flat $300 payment because it is a legislatively mandated benefit. In recent years, some Medicare carriers have initially rejected claims for home dialysis training services, but they are virtually always paid after appeal.

Are providers allowed to perform their face-to-face training notes at the same time as the monthly comprehensive visit? I can’t find any documentation that says you can’t, but I want to be sure.

It is RPA’s understanding that the home training services and the monthly complete assessment visit can occur on the same day and during the same visit. We recommend that the nephrologist and staff generate completely separate documentation for these services, including different documentation for the different work that was performed.

When following a transient patient at an in-center unit, do we submit a per diem charge for each day they dialyze? Example: patient dialyzes on MON-WED-FRI. So, there would be 3 per diem charges? Or would there be 5 for MON thru FRI?

The nephrology practice can bill for every day for which they have medicolegal responsibility for the patient, so the answer, in this case, is that the practice can bill for five counts of CPT code 90970 (the outpatient daily dialysis code), not just the days that the patient dialyzes. This accounts for the fact that if the patient were to have an adverse event on a non-dialysis day, it is that nephrology practice that would be called to manage the situation. It is important to bear in mind that even though it is a daily code, in theory, it is still a captitated service, which is reflected in the reimbursement ($37.77 on a national average basis for 2021, 1/30th of the national average MCP).

We see a patient who is being treated in the outpatient hospital setting. They are an ESRD patient, but we aren’t the MCP provider. Would this be billed as a per diem visit?

Assuming that the physician seeing the patient in the outpatient setting is not part of the same practice (as defined by tax identification number—TIN) as the MCP physician, he or she could bill either a daily service (90970) or an observation code if the patient is admitted to the observation setting. For an observation note, it needs to document a need greater than just for dialysis. If the patient is justifiably in observation status, the associated service does have greater RVU productivity assigned to it.

I have a billing/coding question concerning Transitional Care Management (TCM) Services. I know interactive contact within 2 business days following the patient’s discharge via telephone, email or face-to-face is one of the requirements. I have a patient who was discharged yesterday. No contact was made yesterday, but I saw him today in the unit and went over everything I would have gone over concerning his discharge face-to-face. Can this encounter meet both the initial interactive contact requirement and the face-to-face visit requirement, or would this visit be considered the interactive contact which would need to be documented, and the next time I saw him in the unit, I could bill the TCM visit? Thanks for clearing this up!

Yes, the encounter does fulfill both requirements, so you can bill the TCM service, but as with other multiple service encounters, the documentation should be separate and distinct.

A provider’s patient is receiving dialysis and asks to be seen for a cold and the nephrologist prescribes the patient medication. Can the provider bill for that? It would be 2 different types of service but what would the place of service be if he’s not seeing the patient in the office?

If the physician saw the patient in their office, or in an office part of the dialysis facility (assuming they lease space there at fair market value or have a similar arrangement), then they could bill for an office visit for the non-dialysis care of a cold. However, if this was done in the dialysis facility while rounding on dialysis patients, it is part of the capitiated payment for the MCP.

If a patient is no longer accepted by any dialysis clinic (behavioral issues) in the city and comes to the ER 2-3 times a week, then how do we correctly code/bill? We have to see the patient/patients and order dialysis. (They are observation only). Can we ever bill for the MCP for this patient?

The MCP should not be billed for such patients and, given that the practice is not actually following the patient, the practice should bill the daily dialysis code (90970) only for the days they dialyze the patient. However, the use of CPT code 90970 is the appropriate answer for dialysis only, so if there is an assessment needed and performed for virtually any other condition, use of the appropriate emergency room E&M code (CPT code 99281-99285) would be allowable.

Is it allowable to do a comp visit for dialysis during an OBS stay in the hospital? I’m assuming POS would be an issue with that. I have always heard only basic visits can be done during OBS stay in the hospital but want to verify.

Presuming that you’re referring to the elements of the MCP for monthly outpatient dialysis patients, our understanding is that there’s nothing preventing a nephrologist or advanced practitioner from performing the complete assessment in the observation setting—CMS/Medicare has never commented on this specifically to our knowledge but has said that all of the services can be provided in all outpatient sites of service, thus RPA’s interpretation is that there is nothing preventing the complete assessment from being provided in the observation setting and being paid. That said, as noted the place of service on the claim could be an issue that can cause denial and require an appeal. Further, if the patient ends up being admitted after the complete assessment visit was done, the billing will need to be switched to inpatient charges, which puts the provider in jeopardy for not being able to bill for the 90960-90962 codes for the month, as the complete assessment would no longer count, since the patient was admitted from OBS. All in all, it is a gray area, and RPA would highly recommend conducting complete assessments in the dialysis unit early in the month to avoid missing it for the month due to issues like this.

Editor’s Note: RPA consciously takes a conservative position when providing coding and billing advice to its members, since the possible unintended consequence of taking a less conservative approach could be a claims audit with the potential of doing tremendous harm to an RPA member’s practice. Similar to the FAQ page on the RPA website, this column has been designed as a general information resource. It is not intended to replace legal advice. The responses to the questions submitted to the Coding Corner column have not been vetted by attorneys, and attorneys have not been consulted in the drafting of any of the replies.
What Members Are Saying About RPA

The value of an annual RPA membership easily outweighs the cost! There are many complexities to the specialty of nephrology, from clinical to billing, and everything in-between. Being a nephrology-specific association, RPA can be considered as a “one-stop shopping” resource for physicians, administrators and advanced practitioners. Resources relevant to advocacy, billing and coding, practice management, leadership and clinical are available in many different formats and tools (webinars, seminars, white papers, meetings, social media, etc.). One of the most valuable resources for me is, and has been, the networking…having your peers available for questions, advice, feedback, etc., is priceless!

Toni Ambrosy
Practice Manager
North Houston Nephrology and Diagnostic Associates PA

I find it easy to renew my RPA membership of $425 because that $425 a year is equivalent to (~$8 a week) a “fancy” coffee drink at Starbucks weekly. The coffee drink gives me caffeine and calories. My RPA membership gives me the tools I need to succeed in practice as well as a community with common interests. RPA gives you everything you need to succeed in nephrology practice that you didn’t learn during your fellowship. It is easy to get involved - join a committee, sign up for PAL, submit questions via the RPA app, reach out to a Board member and find a mentor.

Gary G. Singer MD FACP
Adult Nephrologist
Midwest Nephrology Associates, Inc

I know that the e-learning platform comes with my membership! I love having that resource available to me. I dedicate Wednesday as a “learning day” and I will play a session or two from the vast library as a refresher. RPA provides a real community of people (and experts) who understand what you are doing and what battles you are facing. The members are generous with their experience and advice. In my area, I know no other nephrology practice managers and the RPA fills that void with peers who “get it”. My RPA membership allows me to build real relationships with fellow members and grow a network of friends and contacts on whom I can rely on for answers to questions or to provide a sounding board. RPA Mobile App provides an instant platform to pose a question and get answers and opinions.

Stacey Loomis, CMPE
Practice Manager
Midwest Nephrology Associates, Inc.

If I could tell a non-member 1 exceptional thing about RPA, I would say RPA is about the experience. The RPA is not a mere subscription or membership. The RPA is an experience. Where else would you have direct access to the leaders of large dialysis organizations, nephrology practice managers, and nephrology physician leaders. The RPA is undoubtedly unique.

Mo Alzuabaidi, MD, FASN, FNKF, QIA
Early Career Physician, Nephrologist, HTN Specialist, Apheresis Specialist
Columbia Nephrology Associates

I gladly pay my dues to RPA every year because RPA is the best resource for the business of nephrology – they are our advocate for payment, policy, billing and coding issues. The RPA looks out for us as nephrologists so that we are paid fairly to take care of our complex patient population. Other organizations are better with the science of nephrology but RPA is the best with nephrology business and politics.

Shaun Conlon, MD
Early Career Physician
Atlanta Nephrology Associates

I find writing my renewal check for $200 worth every penny! Amazing network and supportive members, excellent information, and friendships with colleagues from all over the US. I also learn a ton and get to build leadership experience. RPA is very friendly and have supportive members that truly want to help each other. If I could tell a new member 1 exceptional thing about RPA, I would tell them to get involved with RPA committees; attend a meeting and/or a webinar and it will improve your overall practice. And find time to network and make friends.

Samaya J. Anumudu MD
Early Career Physician
Baylor College of Medicine

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Renew your 2022 membership at www.renalmd.org