



August 12, 2019

Seema Verma, MPH  
Administrator  
Centers for Medicare and Medicaid Services  
Attention: CMS-6082-NC  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Re: CMS-6082-NC: Request for Information; Reducing Administrative Burden to Put Patients Over Paperwork

Dear Administrator Verma:

The Renal Physicians Association (RPA) is the professional organization of nephrologists whose goals are to ensure optimal care under the highest standards of medical practice for patients with kidney disease and related disorders. RPA acts as the national representative for physicians engaged in the study and management of patients with kidney disease.

RPA is writing in response to the Centers for Medicare & Medicaid Services' (CMS) Request for Information (RFI); Reducing Administrative Burden to Put Patients Over Paperwork. We commend HHS and CMS for the Administration's consistent efforts to reduce the administrative burdens placed upon nephrologists, all physicians, and other Medicare Part B providers, and we similarly appreciate the intent and substance of the Advancing American Kidney Health Initiative (AAKHI) announced by the Administration earlier this summer. These comments will primarily focus on kidney-specific administrative burdens, but will also discuss broader Medicare-related health care delivery concerns.

These comments will address the following issues:

- **Repetitive Documentation Requirements for Kidney Transplant Patients**
- **Streamlining of the Medicare 2728 ESRD Evidence Form**
- **Redundancy of Data Entry for ESRD Patients Due to Insufficient Interoperability**
- **Prior Authorization**
- **Cost-Sharing Requirements for Kidney Disease Education and Care Management Services**
- **Oversight of Medicare Administrative Contractors (MACs)**

## **Repetitive Documentation Requirements for Kidney Transplant Patients**

As noted, RPA was tremendously encouraged by the proposals set forth in the AAKHI, and while many of the details associated with the proposals must still be determined, the initiative as a whole is indicative of a commitment to make the care provided to the nation's kidney patients less burdensome and more effective. In this spirit, RPA urges CMS to address the unnecessary requirements associated with patients who have received a kidney transplant and are prescribed immunosuppressive drugs and other medications to promote the continued viability of the graft. CMS requires pharmacies to request that nephrologists document the date of transplant, place of transplant, discharge date and Medicare eligibility for these drugs. It is our understanding that CMS actually has all of this data but still mandates that pharmacies ask for specific information with each refill of transplant medications. Thus, not only does CMS have this information, the pharmacy also already has the information, and it only changes if the patient has another transplant. **RPA strongly urges CMS to streamline its requirements for documentation supporting transplant medications so that monthly documentation of information that both CMS and the pharmacy already have is not required, and instead consider a requirement for an annual review of these medications.**

## **Streamlining of the Medicare 2728 ESRD Evidence Form**

Acknowledging that the Medicare 2728 ESRD Evidence Form was updated in 2015 in advance of the transition to the ICD-10 diagnosis coding system on October 1 of that year, RPA continues to believe that the number of potential diagnoses listed as potential causes of ESRD is much too long. As noted in our comments on the draft revision in 2015, the 2728 form continues to include far too many diagnosis codes, many of which are peripheral but more often clearly are not indicative of the cause of ESRD. Acknowledging that the shift to ICD-10 inherently involved the use of more diagnosis codes in general, this is less true in kidney disease and nephrology than other disease states and specialties, and the inclusion of so many superfluous diagnosis codes on the 2728 serves little purpose.

For example, the 2728 continues to include codes that lack sufficient specificity to either be indicated as a primary cause of ESRD (as required), or to have downstream benefit in the context of data gathering (such as any code, usually ending in '9, that uses the terms "other" or "unspecified"). **RPA therefore urges CMS to work with the kidney community to further review the diagnoses codes listed on the Medicare 2728 ESRD Evidence Form to reduce the number of superfluous codes listed.**

## **Redundancy of Data Entry for ESRD Patients Due to Insufficient Interoperability**

As noted in RPA's comments to the Office of the National Coordinator for Health Information Technology on the 21st Century Cures Act pertaining to Interoperability, ESRD patients need frequent, ongoing dialysis care. They typically have multiple chronic conditions that require numerous prescribed medications, treatment plans, and lab tests from multiple sources, and receive care in multiple settings of care, including the nephrologist's office, the dialysis facility,

and hospitals. When there is insufficient interoperability of electronic health record systems among these providers, nephrologists are affected in that it can result in duplicate documentation depending on which entity ‘owns’ the medical record. For example, a nephrologist will document pertinent information for an in-center visit with a dialysis patient in the dialysis facility’s EHR, but if there is a lack of interoperability between the nephrologist’s office and the dialysis facility (or if the dialysis facility’s documentation system is proprietary), the nephrologist may have to document that information a second time in the nephrology practice’s EHR. This results in unnecessary burden and cost to nephrology practices, and competes with the need to efficiently use the limited time available to provide a kidney patient’s direct clinical care. It also promotes a “check the box” approach, rather than meaningfully advancing patient care. **RPA therefore urges CMS to highly prioritize its work with the ONC to promote optimal use of interoperability to reduce if not eliminate unnecessary burdens to nephrologists in their documentation of kidney disease care.**

### **Prior Authorization**

RPA concurs with the American College of Physicians (ACP) and the American Medical Association (AMA) that for organized medicine broadly, inappropriate use of prior authorization (PA) requirements by insurers is among the most burdensome paperwork activities associated with health care delivery in the U.S. It is antithetical to both value-based and individualized patient care. PA questions the physician’s clinical judgment, often leads the clinician to make unnecessary referrals to specialists such as nephrologists, and delays needed care. **RPA strongly urges CMS to curb inappropriate use of PA, including but not limited to the following situations: (1), when the PA is of low value, such as for services and/or drugs that are uniformly approved; (2) when it is used to deny services/drugs in instances when they were previously approved; (3) when peer-to-peer reviews are not made by physicians from the same specialty/subspecialty as the ordering or prescribing physician; and (4) except where there is evidence of widespread misuse, PA should not be required for drugs that are standard treatment for the patient’s condition and/or have been previously approved for treatment of an ongoing/chronic condition.**

### **Cost-Sharing Requirements for Kidney Disease Education and Care Management Services**

In its comments on the RFI for Patients Over Paperwork, the AMA urges CMS to eliminate the cost-sharing requirements for the chronic care management (CCM), transitional care management (TCM), and other care management service code families in order to improve utilizations of these services by removing a barrier to their use. RPA concurs with this recommendation and would add the kidney disease education (KDE) codes (G0420 and G0421) to this request. The KDE service codes have been underutilized since their creation for the 2010 Medicare Fee Schedule, and at that time RPA was contacted by numerous nephrology practices that were enthusiastic about providing the service, only to realize it would force the practice to bill patients for additional services. RPA believes this request fits in well with the Patient Over Paperwork effort in that it would reduce the paperwork associated with billing for the KDE services, and their increased use would be in perfect alignment with the AAKHI program to

improve the nation's kidney health. **RPA therefore strongly urges CMS to eliminate the cost-sharing requirements for not only the CCM and TCM service code families but also for the KDE codes.**

### **Oversight and Transparency of Medicare Administrative Contractors (MACs)**

RPA appreciates the efforts that CMS has taken in the past year to enhance the uniformity of policy development by the Medicare Administrative Contractors (MACs) nationwide, specifically in revising the relevant chapter of the Medicare Program Integrity Manual on the local coverage determination (LCD) process. Improvements such as these allow nephrologists and other physicians to focus on the care they provide to Medicare beneficiaries without having to be unduly concerned about local policy development that might interfere with patient care.

We urge CMS to remain vigilant in this regard. Over the past two years the MACs have been seeking to implement an LCD that would limit the number of reimbursed dialysis sessions a patient can receive in a month's time, regardless of whether or not in the nephrologist's clinical judgment they are medically necessary. This year, the MACs issued revised LCDs that seemed to partially address the concerns of the kidney community regarding the nephrologist's ability to prescribe additional dialysis sessions, but more recently several MACs have issued billing articles that rather than providing clarity on the revised policies, have confused the issue and thus continued the reluctance of nephrologists and dialysis centers to provide the additional services. To be clear, many patients who need additional dialysis in a month and do not receive it will face an increased likelihood of an emergency room visit to address fluid overload and other conditions associated with dialysis inadequacy, with all of the attendant care delivery and Medicare program cost implications associated with the unnecessary ER visits.

Given that a primary benefit of home hemodialysis (HHD) is achieved through an increased frequency of sessions, it seems counterintuitive and confounding that the MACs would not issue clear policy allowing the additional services (with well-defined safeguards) at a time when the Administration is seeking to promote home dialysis. This lack of clarity not only is directly counter to patient-centric care but also results in undue administrative burdens for the nephrology practices seeking to ensure that their ESRD patients receive the appropriate dialysis prescription for their specific condition. **For these reasons, RPA strongly urges CMS to continue its efforts to enhance the policy development process at the MAC level to ensure that consistent and clear payment and coverage policies are developed.**

As always, RPA welcomes the opportunity to work collaboratively with CMS in its efforts to improve the quality of care provided to the nation's kidney patients, and we stand ready as a resource to CMS in its future work to reduce administrative burdens on nephrologists and other Medicare providers. Any questions or comments regarding this correspondence should be directed to RPA's Director of Public Policy, Rob Blaser, at 301-468-3515, or by email at [rblaser@renalmd.org](mailto:rblaser@renalmd.org).

Sincerely,

A handwritten signature in black ink that reads "Jeffrey A. Perlmutter MD". The signature is written in a cursive style with a prominent initial "J" and a stylized "P".

Jeffrey A. Perlmutter, MD  
President