



June 1, 2020

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
ATTN: CMS-1744-IFC
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CMS-1744-IFC; Medicare Program; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency; Interim Final Rule with Comment

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. Part of RPA's mission is to promote excellence in the delivery of high-quality kidney care within an environment that supports patient access to care and safety.

RPA is writing to offer our input on the IFC addressing Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency. Broadly, **RPA strongly commends the swift and comprehensive nature of CMS' rulemaking compromising the IFC, specifically with regard to telehealth.** The Agency's response facilitated the ability of nephrologists and all physicians to maintain the level of high-quality care typically provided to their patients under exceptionally trying circumstances, and RPA greatly appreciates CMS' efforts in this regard.

RPA's comments address the following issues:

- **Nephrology-Specific Revisions**
- **Place of Service and the New Telehealth Modifier**
- **Telephone Codes**
- **Providing Services to New Patients Via Telehealth and Telephone**
- **Beneficiary Cost-Sharing Obligations and Patient Consent**
- **Addition of Acute Kidney Injury and Home Dialysis Training Codes to Approved Telehealth Service List**

Nephrology-Specific Revisions

In the interim final rule CMS clarified that all monthly dialysis services are included on the approved telehealth list, and that all of the patient-physician interactions associated with these

services could be provided by telehealth. RPA has long held that when possible weekly, face-to-face interactions between patients and nephrologists is the ideal frequency of care associated with the end-stage renal disease (ESRD) monthly capitated payment (MCP) family of service codes, and that when through the use of personal protective equipment (PPE) and social distancing these interactions can still occur on a face-to-face basis, they should happen as often as possible, even during the public health emergency (PHE). However, **there will be situations during the PHE when concerns about the safety of the dialysis patients and nephrologists override the necessity of face-to-face interactions, and we completely support CMS' decision to allow these services to be fully provided via telehealth.**

Further, **we believe the Agency made the correct decision to lift the requirement that the clinical examination of the dialysis patient's vascular access site must be furnished face-to-face and "hands on" (without the use of an interactive telecommunications system) by physician, clinical nurse specialist (CNS), nurse practitioner (NP), or physician assistant (PA)).** This policy decision for the duration of the PHE will reduce the potential for viral spread and is the right call.

Place of Service and the New Telehealth Modifier

RPA supports CMS' revised guidelines for designating the place of service that would have been reported had the service been furnished in person, and using the -95 modifier to identify services provided by telehealth, and the rationale behind those decisions. **Establishing payment parity for all services provided via telehealth will serve to maximize the safety of health care delivery during the PHE and will provide further support to physician practices adversely affected by the substantial workflow changes brought on by the pandemic.**

Telephone Codes

CMS' decision to designate the family of audio-only telephone codes (CPT codes 99441-99443) as covered services (changing the status indicators from an inactive status ('N' for non-covered) to an active status ('A', indicating a covered service)) was an appropriate decision that will enable nephrologists to provide care to kidney patients who may have issues with travel or may not have access to or be adept with technology. RPA was an advocate for this policy change, and we appreciate the Agency's wisdom in moving forward with it.

In addition, in subsequent rulemaking CMS established equivalent payment rates between the mid-level established patient office visit service codes (CPT codes 99212-99214) and the telephone code family. RPA believes that this revision will be of substantial benefit to Medicare beneficiaries as it will facilitate the delivery of their care when circumstances might otherwise be difficult, and RPA supports this decision.

Providing Services to New Patients Via Telehealth and Telephone

In the interim final rule, CMS indicated that telephone services could be provided to new patients, in addition to established patients. This followed policy revisions in previous rulemaking that clarified that all of the codes on the updated approved telehealth list at that point

could be provided to new patients as well. As with CMS' telehealth-related policy changes outlined above, RPA appreciates and supports these wise decisions.

Beneficiary Cost-Sharing Obligations and Patient Consent

CMS also reiterates in the interim final rule the statement previously made by the HHS Office of Inspector General (OIG) that Medicare physicians and providers will not be subject to administrative sanctions for reducing or waiving a beneficiary's cost-sharing obligations. The OIG policy statement notes that while nothing requires the physician practice to do so, there will be no sanction if the practice does waive cost-sharing obligations. The rule specifies that this policy "applies to a broad category of non-face-to-face services furnished through various modalities, including telehealth visits, virtual check-in services, e-visits, monthly remote care management, and monthly remote patient monitoring." RPA believes this policy strikes the right balance and will allow physician practices greater flexibility in collecting patient out-of-pocket costs.

Similarly, CMS is easing requirements regarding efforts to obtain patient consent. CMS' statement that "beneficiary consent should not interfere with the provision of telehealth services. Annual consent may be obtained at the same time, and not necessarily before, the time that services are furnished." Given the rapid adoption of telehealth in U.S. physician practice, RPA again believes the Agency made the appropriate decision on patient consent, and we appreciate how this decision is reflective of real-world health care delivery.

Addition of Acute Kidney Injury and Home Dialysis Training Codes to Approved Telehealth Service List

While RPA recognizes that the addition of service codes to the approved telehealth list is not necessarily within the scope of this IFC, we do have two recommendations for additions. First, **RPA recommends that CMS add CPT code 90935 (hemodialysis, single evaluation) and CPT code 90945 (dialysis procedure other than hemodialysis—e.g., peritoneal dialysis) to the approved telehealth list when provided in the outpatient setting.** These codes are used to provide services to patients with acute kidney injury (AKI—i.e., non-ESRD), and given that under current regulations these services can only be provided on either an inpatient basis or in the dialysis facility, this change would enable Medicare beneficiaries with AKI to receive appropriate care via telehealth.

Secondly, **RPA recommends that CMS add the home dialysis training service codes (CPT codes 90989—dialysis training, completed course, and 90993, dialysis training, course not completed; per session) to Medicare's approved telehealth service code list.** We see no reason why home dialysis training cannot be personally supervised by the nephrologist through use of the interactive, audio-video technology that is required for providing services by telehealth in the Medicare program. Further, we believe that expanding the possible means by which home dialysis training can be provided will only serve to increase the use of home dialysis, an explicit and primary goal of the Administration's Advancing American Kidney Health initiative.

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 on changes affecting Medicare coverage and payment policy. 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.

Sincerely,

A handwritten signature in black ink, reading "Jeffrey A. Perlmutter" with a stylized flourish at the end.

Jeffrey A. Perlmutter, MD
President