



Major Victories for Nephrology in 2021 Medicare Fee Schedule Proposed Rule

- **RPA Recommendations on Revaluation of Outpatient Dialysis Codes Implemented**
- **Nephrology Reimbursement Slated for 6% Increase**
- **Conversion Factor Decreased by 11% Due to Budget Neutrality**
- **Inpatient Dialysis Codes Reduced Due to Conversion Factor Cut**
- **Most Established Patient E&M Codes Have Substantial Reimbursement Increases**
- **Streamlined E&M Documentation Guidelines Finalized**

The proposed rule for the 2021 Medicare Fee Schedule was released on August 4, and there was significant positive news for nephrology. CMS acted on RPA's recommendation to increase RVUs for the outpatient dialysis codes based on increases in the underlying evaluation and management (E&M) building block codes over the past fifteen years. **Every code in the code family, adult and pediatric, in-center and home, monthly and daily, is increased.** The proposed increase in total RVUs by percentage for several high-volume adult dialysis codes is:

- CPT code 90960 (monthly dialysis, four visits)—29%
- CPT code 90961 (monthly dialysis, two-three visits)—27%
- CPT code 90962 (monthly dialysis, one visit)—13%
- CPT code 90966 (monthly home dialysis)—27%
- CPT code 90970 (daily dialysis)—22%.

Nephrology as a specialty is expected to experience an average 6% increase

However, not all the news is positive. First, CMS did cut the conversion factor to account for budget neutrality; the proposed CY 2021 PFS conversion factor is projected to be \$32.26, a decrease of \$3.83 from the CY 2020 PFS conversion factor of \$36.09. Even with this significant cut, all the outpatient dialysis codes will have increases in reimbursement, and some of those increases will be huge (the national median payment amount for 90960 is increased from \$291 in 2020 to \$337 in 2021). However, the inpatient dialysis codes and high-volume dialysis circuit codes for vascular access will experience payment reductions; these cuts are described below. **RPA has joined the AMA, ACP, and many other medical societies in calling on Congress to waive budget neutrality for 2021, it is hoped this will occur, and if so, most likely during the post-election lame duck session of Congress.**

As for telehealth, CMS does not propose to permanently waive originating site and geographic restrictions as they do not have the authority to do so, although RPA and many other groups in organized medicine are urging for this change to occur. CMS is proposing to create a third temporary category of criteria for adding services to the list of Medicare telehealth services. Category 3 describes services added to the Medicare telehealth list during the public health emergency (PHE) for the COVID-19 pandemic that will remain on the list through the calendar year in which the PHE ends.

This summary addresses these and other issues outlined in the proposed rule.

Nephrology-Specific Issues

The big news for nephrology in the fee schedule is the increase in value for the outpatient dialysis codes. The changes for 2021 were the result of CMS specifically soliciting comment on families of services for which the values are closely tied to the values of the office/outpatient E&M visit codes (including the outpatient dialysis code family), and whether it would be necessary or beneficial to make systematic adjustments to other related fee schedule services to maintain relativity between these services and office/outpatient E&M visits. RPA's comments on this point are excerpted below:

As CMS knows, valuation of the monthly ESRD codes have long been based on E&M services. In the December 8, 1994 issue of the Federal Register setting forth the Medicare Fee Schedule for 1995, then-HCFA established a process for development of work values for the Monthly Capitated Payment (MCP) for ESRD services that utilized different office visit codes as "building blocks" for the MCP. HCFA noted that the mix of the "visit code building blocks most appropriately represents the typical mix of encounters with the ESRD patient who is dialyzed in an ESRD facility and accounts for the service intensity and complexity of decision-making and the pre-service and post-service work for a month's care of a typical dialysis patient." A panel of carrier medical directors (CMDs) that included a representative of the RUC determined that the appropriate building block mix was four counts of the work RVUs for CPT code 99212 and two counts of the work RVUs for CPT code 99214.

These values remained in place until the rulemaking cycle for the 2004 Medicare Fee Schedule, in which now-CMS established a stratified MCP payment system based on the number of face-to-face interactions between the MCP physician and the ESRD patient. This system established a mid-level adult MCP code (G-0318) based on the previous adult MCP code (CPT code 90921) and representing 2-3 physician-ESRD patient interactions, and provided additional RVUs for 4 physician-ESRD patient interactions (G-0317) and fewer RVUs for 1 physician-ESRD patient interaction (G-0319). This methodology was also applied to the pediatric series of monthly dialysis services, codes G-0308-G0310 for

patients less than two years of age, codes G-0311-G0313 for patients between the ages of two and eleven, and codes G-0314-G0316 for patients ages twelve to nineteen.

When the Five-Year Review of E&M Codes increased the work RVUs for selected E&M codes in 2006, the E&M value increases were applied to all global surgical packages with E&M elements. However, these increases were not applied to the family of ESRD MCP codes. As a result, RPA petitioned CMS to apply these increases in the MCP building block codes to the current MCP as part of its comments on the 2007 Medicare Fee Schedule Proposed Rule. RPA's recommendation called for CMS to revise the ESRD MCP codes based on the previously determined building blocks and using the mid-level code (G-0318) since that code most closely approximated the previous adult MCP code (CPT code 90921), with the same methodology being applied to the pediatric series of monthly dialysis services. This recommendation was not accepted, and CMS referred RPA to the AMA Relative Value Update Committee (RUC) to determine the current valuation of the services associated with the ESRD MCP G-codes. The codes were valued by the RUC in early 2008 and the values emanating from that RUC meeting form the basis for the valuation of the monthly ESRD services in the fee schedule today.

RPA believes that adjustment of the family of monthly ESRD service codes based on the increase in underlying E&M services is long overdue. The original component building blocks codes for the MCP (CPT codes 99212 and 99214) have seen multiple increases in value since the MCP was first transitioned into the RBRVS, and the subsequent increase to global surgical packages based on E&M code revaluation since then was not applied to the MCP code family.

*Such a change would also be reflective of the Administration's appropriately increased focus on Advancing American Kidney Health. The nation's chronic kidney disease (CKD) patient population continues to grow rapidly and providing nephrology practices with additional resources to provide care to dialysis patients (only by providing increases in value commensurate with value adjustments for their underlying building blocks) would be of tremendous benefit to outpatient kidney disease care. **Therefore, RPA recommends that CMS adjust the ESRD monthly service codes to reflect previous increases in underlying E&M services.***

RPA has been petitioning CMS to revalue the outpatient dialysis code family based on increases in their underlying E&M component codes that occurred several times since 2006, and have proposed to make these changes for 2021.

As for other points specifically pertaining to nephrology, the specialty impact chart included in the proposed rule indicates that **nephrology is projected to experience an estimated 6%**

increase for 2021. This places nephrology in the mid-range of impacts, with some specialties being slated for either double-digit increases, or decreases of similar magnitude.

With regard to inpatient dialysis services, all four service codes (CPT codes 90935, 90937, 90945, and 90947) will experience incremental increases in value for 2021, but with the reduction in the CF are proposed to have a substantial reduction in payment for 2021; for example, CPT code 90935, hemodialysis, single evaluation, is slated to have a median national payment of \$67.74 for 2021, as opposed to \$75.06 for 2020.

On the interventional side, the large volume dialysis circuit codes will also be adversely affected by the conversion factor reduction. CPT codes 36902 and 36905 (both balloon angioplasty services) each have RVU increases of 7% and 8%, respectively, but because of the CF cut will experience payment reductions of 4% and 3%, respectively.

Conversion Factor

As referenced above, the proposed CY 2021 PFS conversion factor is projected to be \$32.26, a decrease of \$3.83 from the CY 2020 PFS conversion factor of \$36.09, an approximate 11% reduction that causes the above referenced double-digit decreases in yearly impacts for some specialties and subspecialties resulting from Congressionally mandated budget neutrality. For now, the CF cut will be required in 2021 to offset the payment increases for office visits and other services (including the dialysis code family). This has been an issue especially for procedurally based societies since its rollout in 2019 and there will be intense lobbying to waive budget neutrality before year's end; RPA will be supporting these efforts.

Evaluation and Management (E&M) Services

The value increases for evaluation and management services first proposed in the 2020 rule have in essence been finalized, so all E&M codes will have RVU increases. However, this is another area where the CF cuts reduce or even eliminate the RVU gains. Most of the new patient office visit codes (CPT codes 99202-99204) will have reimbursement decreases when the RVUs and the CF have been accounted for, while 99205 will have a modest 0.4% increase for 2021. **Much more positive news is on the established patient E&M side, where the only code experiencing a reimbursement hit is 99211 (-3.5%), while all of the other established patient codes have reimbursement increases, all sizable.** These increases are noted below:

- CPT code 99212 (level two office visit)—18% increase
- CPT code 99213 (level three office visit)—15% increase
- CPT code 99214 (level four office visit)—11% increase
- CPT code 99215 (level five office visit)—16% increase

The established patient E&M code reimbursement increases would presumably be substantially beneficial in the treatment of persons with chronic kidney disease (CKD).

CMS proposes to implement finalized CPT descriptors, guidelines, and payment rates on January 1, 2021, which will be a significant modification to the coding, documentation, and payment of E&M services for office visits. Additionally, positive news in the proposed rule pertains to reduction of E&M documentation burden. As part of the proposed rule for 2020, CMS has indicated that for 2021: (1) the arbitrary “bullet-point” methodology of documenting E&M services will be discontinued (CMS referred to this in last year’s rulemaking cycle as “clinically outdated”), and the level of billing will be determined by either medical decision-making or time; (2) regarding history and physical documentation, it only needs to reflect what is medically appropriate; and (3) if the clinician bases the billing level on time, it will include “the total time personally spent by the reporting practitioner on the day of the visit (including face-to-face and non-face-to-face time)” so time prior to or after the face-to-face interaction with the patient can be included.

Telehealth

While it was anticipated that there might be big news in the area of telehealth in this proposed rule (based on statements by CMS Administrator Seema Verma, among others) major changes did not seem to occur. The Agency does propose adding several codes to the permanent telehealth list, including for prolonged services and home visits. Additionally, CMS addresses the issue of audio-only interactions as follows:

In the March 31st COVID-19 IFC, we established separate payment for audio-only telephone evaluation and management services. While we are not proposing to continue to recognize these codes for payment under the PFS in the absence of the PHE for the COVID-19 pandemic, the need for audio-only interactions could remain as beneficiaries continue to try to avoid sources of potential infection, such as a doctor’s office. We are seeking comment on whether CMS should develop coding and payment for a service similar to the virtual check-in but for a longer unit of time and subsequently with a higher value. We are seeking input from the public on the duration of the services and the resources in both work and practice expense associated with furnishing this service. We are seeking comment on whether this should be a provisional policy to remain in effect until a year after the end of the PHE for the COVID-19 pandemic or if it should be PFS payment policy permanently.

RPA is finalizing recommendations for the use of telehealth in kidney care and will be provide that document to senior staff at the Department of Health and Human Services (HHS), CMS, and on Capitol Hill.

Medicare Diabetes Prevention Program (MDPP)

Although CMS has permitted many MDPP services to be provided virtually during the COVID-19 public health emergency, it still requires the first core session to be provided in-person, which prevents any new patients from participating. The proposed rule would drop that requirement and allow all MDPP services to be delivered virtually during the current emergency as well as in future declared emergencies. CMS also proposes to allow patients to report their weight through virtual means, such as Bluetooth scales. The proposed rule stops short of allowing providers of virtual-only DPP services to enroll as MDPP suppliers, however.

Summary

This is a complex fee schedule rule even by the standards of previous Medicare Fee Schedules. RPA will continue to analyze the rule's proposals to discern any further meaningful impact on nephrology practices. RPA will also continue to advocate for the waiving of budget neutrality in the conversion factor throughout the fall, both as an individual organization and within the context of coalitions. Comments on the proposed rule will be submitted to CMS on or around October 4, 2020. RPA's comments will be posted at www.renalmd.org after that date.