2020 Medicare Fee Schedule Final Rule: Provisions that Impact Nephrology

On November 1 CMS issued the final rule for the 2020 Medicare Physician Fee Schedule which has minimal changes from what was outlined in the proposed rule from July. CMS finalized its proposals to allow for billing of transitional care management (TCM) codes for monthly dialysis patients and to update the structure and valuation of evaluation and management (E&M) services. In addition, payment for all dialysis codes is incrementally increased. However, on issues pertaining to quality measures, CMS eliminated the nephrology-specific measure set and implemented an episode-based quality measure for Acute Kidney Injury Requiring New Inpatient Dialysis; RPA’s opposed these provisions in its comments on the proposed rule.

This summary addresses these and other issues of consequence for nephrology pursuant to the release of the 2020 fee schedule final rule; comments on the final rule are due on December 31, 2019.

Nephrology-Specific Payment Issues

On payment issues specific to nephrology, the specialty is slated for a 0% impact for 2020. All dialysis codes, inpatient and outpatient, adult, pediatric and daily, experience increases of between 0.1% and 1.0% (except for CPT code 90970, the adult daily dialysis code, which was increased 4.5%). For CPT code 90960, the adult in-center, four-visit code, the increase is 0.8%, which with the increase in the conversion factor (discussed below) works out to a $2.21 increase (unadjusted for geography), while CPT code 90935 (hemodialysis, single evaluation) is increased by 0.4%, working out to a $0.32 bump. Regarding the dialysis circuit codes for interventional dialysis services, the two high volume codes, CPT codes 36902 (angioplasty) and CPT code 36905 (thrombectomy with angioplasty) experience 2.5% and 3.0% increases when these services are provided in the physician office setting.

One bit of very positive news is that CMS also made final its decision to allow billing of the transitional care management (TCM) codes (CPT codes 99495 and 99496) in conjunction with the adult outpatient dialysis codes (CPT codes 90960, 90961, 90962, 90966, and 90970); previously, billing the TCM codes on ESRD patients had been prohibited. What this means for a nephrology practice is that if you follow a patient after discharge and comply with the documentation and other requirements of the TCM codes, you can bill Medicare and be reimbursed approximately $187.67 for CPT code 99495 (this is the 14-day post-discharge code) and $247.93 for CPT code 99496 (the 7-day post-discharge code).
In the context of revaluation of the outpatient E&M code families for 2021, CMS stated in the proposed rule that it recognizes there are services other than the global surgical codes for which the values are closely tied to the values of the office/outpatient E/M visit codes, including ESRD monthly services (CPT codes 90951 through 90961), and solicited comment on the issue. RPA’s comments on the proposed rule outlined the numerous times that the ESRD MCP building block codes (CPT codes 99212 and 99214) had been increased in value since the creation of the MCP, and accordingly urged CMS to revalue the MCP based on the increases to its component building blocks. The final rule states that “We thank commenters for their thorough recommendations and look forward to considering these recommendations for future rulemaking.” RPA will obviously be tracking developments in this area.

General Medicine Issues

On issues affecting all of medicine, the conversion factor for 2020 was finalized at the proposed level of $36.09, a $0.05 increase over the $36.04 CF for 2019, and as noted above CMS finalized its proposal to accept the RUC recommendations for both E&M coding structure and valuation and not implement the proposed arrangement outlined in the 2019 fee schedule proposed rule that collapsed payment amounts for the higher-level codes into a single level. This decision sustains a huge victory for cognitive care in general, although it appears that the specialty-specific impact of the change for nephrology is -2%. While this impact is unexpected, it should be considered in the context of the cuts expected out of last year’s proposed rule (approximately 13%) and is only a projection.

Also finalized were the proposals to reduce E&M documentation burden. For 2021, CMS has indicated that: (1) the arbitrary “bullet-point” methodology of documenting E&M services will be discontinued (CMS refers to this 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.

The final rule also confirmed CMS’ proposal to create separate coding and payment for Principal Care Management (PCM) services, but with some changes. CMS states in the rule that qualifying conditions for these services “would typically be expected to last between three months and a year, or until the death of the patient, may have led to a recent hospitalization, and/or place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.” Additionally, CMS noted in the rule that the PCM codes would not be billable by the same practitioner for the same patient concurrent with certain other care management services and includes the monthly capitated ESRD codes among these excluded services, with which we agree. RPA comments on the proposed rule noted that “the PCM codes could prove to be useful in the care of CKD patients not yet on dialysis, and thus (we) believe
the proposed PCM codes would provide another avenue toward optimizing care for those patients.”

As for the changes in the PCM services, different codes were assigned to the services, with G2064 being the code for 30 minutes monthly of PCM services provided by a physician, and G2065 for 30 minutes monthly of PCM services performed by clinical staff directed by a physician. Additionally, the RVUs were increased for both services in the final rule over what was outlined in the proposed rule, with the total non-facility (outpatient) RVU for G2064 being 2.55 (for an allowed reimbursement amount of $92.03, unadjusted for geography), and the same RVU for G2065 being 1.10, resulting in an allowed reimbursement of $39.69, unadjusted for geography.

CMS also finalized its proposals regarding physician supervision requirements for physician assistants (PAs) and review of notes by medical students. On the former, CMS states that in the absence of any state rules, CMS is revising “the current supervision requirement to clarify that physician supervision is a process in which a PA has a working relationship with one or more physicians to supervise the delivery of their health care services. Such physician supervision is evidenced by documenting the PA’s scope of practice and indicating the working relationship(s) the PA has with the supervising physician(s) when furnishing professional services.” For review of notes by medical students, CMS will now allow physicians and other qualified clinical staff to “review and verify (sign and date), rather than re-documenting, notes made in the medical record by other physicians, residents, medical, physician assistant, and APRN students, nurses, or other members of the medical team.”

Quality Measurement Issues

Changes to MIPS

RPA comments on the MIPS quality component of the proposed rule noted our appreciation of CMS’ efforts to streamline programs and reduce provider burden but highlighted our concern that the rate at which such changes are being proposed and implemented is counter to CMS’ own goals. RPA stated that the QPP must be allowed to mature, and dramatic changes as proposed with the elimination of specialty-specific measures and the development of the MIPS Value Pathways (MVPs) are premature. Furthermore, continually changing the program has increased provider burden, and potentially burnout, by requiring time away from patients to study changes and implement new workflows, rather than allowing providers the space to understand and comply with the existing components of the QPP.

Unfortunately, despite the objection of RPA and others in the medical community, CMS finalized the removal of all nephrology-specific measures from MIPS.

- MIPS 328 Pediatric Kidney Disease: ESRD Patients Receiving Dialysis: Hemoglobin Level < 10 g/dL
- MIPS 329 Adult Kidney Disease: Catheter Use at Initiation of Hemodialysis
- MIPS 330 Adult Kidney Disease: Catheter Use for Greater Than or Equal to 90 Day
- MIPS 403: Adult Kidney Disease: Referral to Hospice

**Increasing Data Threshold for Quality Measures**

RPA expressed concern that increasing the data completeness threshold from 60% to 70% would increase reporting burden on clinicians with no clear benefit to patient care and disproportionately impact small practices. Despite this, CMS finalized their plan to adopt a higher data completeness threshold for the 2020 MIPS performance period, such that MIPS eligible clinicians and groups submitting quality measure data on QCDR measures, MIPS CQMs, or eCQMs must submit data on at least 70 percent of the MIPS eligible clinician or group’s patients that meet the measure’s denominator criteria, regardless of payer for the 2022 MIPS payment year.

**Acute Kidney Injury (AKI) Requiring New Inpatient Dialysis - Cost Measure**

Despite RPA and the medical community’s concerns regarding the patient level variability in acuity/intensity of care required and attribution issues with the measure, CMS finalized the new AKI cost measure.

**MIPS Value Pathways (MVPs)**

In the final rule, CMS indicates that it plans to go forward with its proposal to implement MVPs in performance year 2021. MVPs would be a defined set of measures and activities, including problematic population-health measures, centered on a condition or procedure. Recognizing comments from RPA and the medical community that opposed the mandatory nature of the MVPs, CMS noted that it had not yet determined whether it would make MVPs mandatory in 2021 and will continue to work with stakeholders to take an incremental approach to determining its policies for 2021.