

RPA News

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Nephrology Practice

Nephrology Slated for 6% Increase in 2021 Medicare Fee Schedule Final Rule

On December 1, the Centers for Medicare and Medicaid Services (CMS) released the final rule for the 2021 Medicare Physician Fee Schedule, and the good news is that, almost across the board, the proposals outlined in August were finalized virtually verbatim. This means that the substantial increases in value for all of the outpatient dialysis codes that were outlined in the proposed rule have been maintained. Additionally, the proposed rule included big increases for most outpatient evaluation and management (E&M) services and added an E&M complexity modifier that will most likely be available for use in the care of chronic kidney disease (CKD) patients; these proposals were finalized as well.

Tempering this positive news is that, because by law the Medicare fee schedule must be budget neutral; therefore, the increases to the dialysis codes, E&M services, and other code families also cause an approximate 10% cut in the conversion factor (CF), the multiplier through which payment amounts for all services in the fee schedule are determined. **The nephrology specialty is slated for a 6% increase as the net result of the increases in value for outpatient dialysis services and the reductions in reimbursement for services such as inpatient dialysis and interventional care due to the CF cut.** The specialty impact chart included in the final rule is provided on page 5.

At press time, there was a concerted effort by procedural specialties and others who do not provide outpatient E&M services to enact legislation before January 1 to roll back what CMS has finalized to mitigate the impact of the CF cut. RPA will keep membership apprised of any developments in this area.

Nephrology Specific Changes

As noted, every code in the outpatient dialysis code family, spanning CPT codes 90951-90970 and including pediatric, adult, in-center, home, and daily codes, received substantial increases

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Earn MOC Credits for QAPI Meetings: Submit by January 29

Don't miss your opportunity to claim 20 Maintenance of Certification (MOC) credits for participating in monthly Quality Assessment and Performance Improvement (QAPI) meetings at your dialysis facility. Nephrologists have until January 29, 2021, to earn MOC credits for 2020 QAPI participation.

The RPA QAPI MOC Program allows nephrologists to claim MOC credits for the quality improvement work they are already doing in their dialysis facilities as part of the Conditions for Coverage (CfC). CfC requires that dialysis facilities hold monthly QAPI meetings where clinical quality data is used to evaluate the effects of the interventions. Although Medical Directors are expected to lead the QAPI process, all of the dialysis facility's credentialed attending physicians may participate in the QAPI process for MOC credit.

Since its launch in late 2016, approximately 2,000 nephrologists have earned MOC credits via the RPA QAPI MOC Program. Nephrologists at participating dialysis organizations who take part in at least 5 QAPI meetings in a 6-month period during 2020 are eligible for the program. Both virtual and in-person meetings count toward the program.

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From Capitol Hill

The Big ‘Now-What’ in Washington

By Robert Blaser, RPA Director of Public Policy

As an undergraduate at a small state college in Maryland, I spent more time than was wise shooting pool, and while this wasn't necessarily the best use of time, there are lessons for both billiards and life that can be gleaned from such experiences. One of these, interestingly enough, is about next steps and planning for the future. There would be times when I made what I thought to be a great shot, only, for example, to leave my ball on the rail behind two or three of the other teams' balls. When this happened, my pool hall partner in those days, a far more skilled player than I, would say, "that's great Rob, nice shot, but now what?" We came to refer to these situations (they happened enough) as the "Big Now What."

Obviously, we are in a big now what situation for Washington, and the nation. As this column is being penned in early December, President-Elect Joe Biden and Vice President-Elect Kamala Harris are poised to ascend to their new positions, and appointees to the new administration are being named daily. However, the Democratic Party can't be celebrating too much, as Congressional Republicans had an unexpectedly strong election, maintaining their control, for now, in the Senate and gaining seats in the House in the face of dire predictions that the GOP would lose 5-15 seats. The run-off elections for the Georgia Senate seats are set for January 5, and nobody should bet the ranch on the Democrats winning both seats (truly, you shouldn't). However, the turmoil amongst Republicans leading up to the election (including President Trump sniping at Georgia Republicans for certifying their election results, and even an online suggestion that the President be a write-in candidate for the Senate seats) combined with a newly robust Democratic infrastructure in the state should make the races at least competitive. And if

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President's Message



Jeffrey Perlmutter, MD
RPA President

As have many, but not all, of you, I received my letter dated November 16 that I have been **SELECTED (!)** to participate in the End Stage Renal Disease Treatment Choices (ETC) Model. At least the notice did not start: The President of the United States to.....Greeting. I wonder if those not included in the ETC got letters notifying them that they were **NOT SELECTED**. As I had noted in my November message, there was no surprise in my selection, as Maryland has an ongoing test of a Total Cost of Care Model, which CMS had already decided guaranteed inclusion in the ETC. The implementation of the ETC in 2021 closes the circle that began when I first started writing this column as RPA President in May 2019. At that time, we were anticipating the AAKHI. The wait is over. The RPA had advocated that the implementation be delayed until after the lifting of the PHE, which is currently set to end on January 20, 2021. It became clear, even before the Presidential election, that CMS was not going to wait until the end of the PHE to begin the new payment models. One can understand the concern that a new administration (which will begin on the date the current PHE ends) or even a change in CMS leadership (HHS Secretary Alex Azar has been a major driver of the AAKHI) could result in the new payment models falling by the wayside. It seems likely that the voluntary CKCC payment models will start during a continuing PHE in April as it is hard to imagine that we will be far enough along in vaccinating people against SARS-CoV-2 to allow for the lifting of the PHE by then. But one can hope.

When I last wrote to you, COVID-19 cases were ebbing. Sadly, they are flowing again. The hospital census of people with COVID-19 where I practice is up to two-thirds of the peak last spring and climbing. The situation for where many of you practice is worse. My observation is that the burden of AKI associated with COVID-19 appears to be less than in the spring. I hope that this is so. Nevertheless, nephrologists have all the challenges of caring for people on dialysis and with CKD regardless of the setting. In my practice, I continued to provide 75% of office visits via telehealth regardless of the phase of opening in my county. The 2021 Medicare Physician Fee Schedule included a provision that the current telehealth regulations will remain in place at least until the end of the year that the PHE ends (2021). I am not even considering a PHE that extends until 2022.

In early December, when I was writing this message, the CDC was meeting to decide on the distribution and tiered administration of the available vaccines for SARS-CoV-2. One hopes for organization and clarity as the vaccine is offered throughout the country. By the time you receive this newsletter, I expect that we will already have been called upon to aid the process as dialysis unit medical directors, but perhaps not yet received instructions on how to guide our office patients. And, of course, you will have had to make the decision on vaccination for yourself.

As I have written previously, during the viral pandemic, the work of the RPA has continued. Our Executive Director, Dale Singer, and

the staff of the RPA have kept our organization in a strong position as an effective advocate for our members and by extension for the people to whom we provide care. Some of us get to thank them often. I urge you to do so by email or even via the old-fashioned postal service.

This work has continued in the areas of legislation and regulation which have become linked with the release of the Medicare Fee schedule. By the time you receive this message, legislation affecting the implementation of the fee schedule may have been passed, as the fee schedule was effective January 1. As our Director of Public Policy, Rob Blaser, has reported and will continue to report, the 2021 fee schedule increased payment for cognitive work, specifically for the monthly dialysis code family, including a proportional increase for the home dialysis MCP. Because the overall fee schedule must remain revenue neutral, the increase in payment for cognitive work caused a significant decrease in the CF, the multiplier for all CPT codes. The CF decreased by more than 10% from \$36.09 to \$32.41. This means the payment for non-cognitive (procedural and other non-E&M work) decreased, on average. As one can imagine, this made the proceduralists very unhappy. They proposed legislation to provide a temporary fix, but that may undo the value increases for cognitive services, and it seems that battles we used to fight about the sustainable growth rate (SGR) could now be fought over the CF. (See article on page 1 for a summary of the 2021 Medicare Physician Fee Schedule Final Rule.)

In other legislative news, the RPA Board voted not to support the BETTER Act, which I discussed in my September message. There does not seem to be much activity in Congress on this bill, but we'll continue to monitor any developments. And of course, the hope is that by the time you read this the immunosuppressive drug coverage bill for which we've all been advocating for what seems like forever will have been passed; of course RPA will report on this if and when it occurs. As always, the RPA will represent the best interests of nephrologists with our elected officials and the Administration.

We have begun promoting our (virtual) annual meeting; registration is open, and the program topics and speakers are posted on the RPA website. Since we did not have a meeting last year, it is even more important that you attend the event in March. Our Education Committee, led by Gary Singer and Brendan Bowman, has been working hard to create a meeting experience that will be informative and fun. I look forward to delivering my Presidential address "in person" and hope that you will be able to participate. I am optimistic that by the time we meet in March that we will again be seeing the ebb of the viral pandemic and the flow of the old normal. ■

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Editor's Expressions



Dale Singer, MHA
RPA Executive Director

Happy New Year! Like me, I'm sure many of you were glad to ring out the old and ring in the new, especially this year. There may have been fewer family members gathered around the Christmas tree last month or fewer relatives joining together to light the Hanukkah menorah, but each of us has found creative ways to celebrate the holidays with friends and family. We are so fortunate to benefit from computer technology that enables us to see and talk with friends and family from all over the world. Relationships that we may have taken for granted or let lapse have been rekindled so that we can share our joy with one another even if we can't travel or be in the same house.

I am personally excited about the prospects for 2021 and the opportunities for RPA to provide added value to each of you over the next 12 months and beyond. While it may be difficult to see any good coming from the COVID-19 pandemic, I believe there have been silver linings that resulted from the virus that will have a long-lasting impact even after a vaccine is widely available.

During 2020, RPA's staff and leadership figured out how to provide relevant education to nephrology professionals through various electronic platforms. Through the wonders of technology, we were able to engage more doctors, advanced practitioners, and practice administrators from all corners of our country without requiring them to leave their homes or offices. Many of these programs were brought to you free of charge through the generosity of our industry supporters.

While we were forced to cancel our 2020 annual meeting due to the country-wide shut down that occurred one week prior to our opening reception, we are looking forward to presenting our March 18-20, 2021 RPA Annual Meeting via an interactive virtual platform complete with easy access to sessions and networking with your colleagues and our industry partners via text or video chat and gamification that will give you bragging rights among your colleagues. We will also be offering our unique and content-rich coding seminar series virtually in April. Watch your email for dates and topics. Part of RPA's mission is to bring nephrology professionals together and we are continuing to do that in new and creative ways.

Speaking of virtual platforms, the 2020 RPA Policy Advocacy Leadership (PAL) webinar series concluded in December with programs focused on Optimal CKD Care and the changes in E&M coding, documentation, and valuation. RPA has developed guidance for large, medium, and small practices to implement optimal CKD care that should be finalized later this month. In addition to sharing examples of how your colleagues provide CKD care in various practice settings, this guidance will address infrastructure needs for providing CKD care in a nephrology practice, how to use patient navigators, and appropriate CPT coding associated with CKD care. Watch your weekly enews for an announcement of the release of this guidance.

We are hopeful that we will be able to gather (and maybe even hug one another) in Dallas in March 2022. But we know that in-person events will look very different on the other side of the pandemic. Looking ahead, we plan to continue to offer a virtual option for our annual meeting to meet the needs of nephrology professionals who are unable or choose not to travel to an in-person event.

Zoom meetings have replaced conference calls for our Board, committee, and workgroup meetings, allowing us to "see" one another more frequently than in previous years. Of course, our staff has been meeting more formally and frequently via Microsoft Teams and sharing updates on tasks in progress to move RPA forward to help you meet and conquer the challenges you are facing every day.

RPA staff and leadership are not merely looking forward to things returning to "normal." Instead, we are preparing for the future by applying lessons learned throughout this pandemic to association operations. This month we are moving to new office space one floor above our current space in the same building that has been designed to ensure the health and safety of our staff while encouraging collegiality. In preparation for the move, all staff were asked to purge extraneous items from their offices and file cabinets. I had not "cleaned house" for 20 years and was amazed by some of the documents I found buried in the file drawers, including handwritten notes from board and committee meetings. Wow, how things have changed—all our notes are now taken on the laptop and all of our board meeting briefing books are electronic. No more three-ring binders!

This pandemic has demonstrated the resilience and adaptability of the RPA staff team who remain committed to serving you, our members, regardless of the curveballs thrown our way. We have revisited our strategic plan that the Board and invited guests drafted in October 2019 and will re-engage the Board in a dialogue about association priorities during the mid-January Board of Directors meeting. We are not waiting for the pandemic to be behind us before we move forward, but rather we are figuring out how to adjust our tactics to achieve the implementation of the association's goals and objectives. I encourage you to stay connected to RPA and the latest legislative and regulatory developments through our app—if you haven't downloaded it yet, go to the Apple or Google Play store and search Renal Physicians Association to install it on your mobile devices. It's free and gives you early access to the latest news affecting your nephrology practice.

With your unwavering support, we are confident that we will continue to provide you with the tools, resources, and support you need to deliver high-quality care to the nation's kidney patients. ■

MOC Credits

from page 1

The following dialysis organizations are participating in the 2020 Program:

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

Nephrologists affiliated with any of the organizations listed in the box may register and view detailed instructions at renalmd.org/page/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.

Upon registration, RPA collects data directly from participating nephrologists including the facility name, dates of participation, and the topic(s) reviewed via a portal of the RPA Kidney Quality Improvement Registry. No clinical data is shared with RPA. Following verification by the facility, RPA transmits the verified data of the nephrologist's participation to ABIM, and ABIM issues the MOC credit. Nephrologists are notified that their MOC credit has been assigned via an automated email from ABIM. They may also access their Self-Evaluation Activity Report on the ABIM website to confirm the MOC credit has been granted. **Nephrologists have until January 29, 2021, to complete their 2020 submission.** Questions about this program should be directed to abeckrich@renalmd.org. ★■

2021 Medicare Fee Schedule

from page 1

in value, ranging from relative value unit (RVU) increases of 13%-27%. The impact of the finalized increases in total RVUs by percentage for several high-volume adult dialysis codes is outlined below:

- 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%

CMS’ decision to finalize the increases in outpatient dialysis codes is the culmination of almost 15 years’ worth of RPA advocacy efforts to restore relativity between the outpatient dialysis services and the E&M services that served as component building blocks for the MCP codes when they were created. The E&M component codes were increased several times since 2006, but the MCP codes were not, and when CMS solicited input on this issue during the 2020 rulemaking cycle, RPA was prepared with the specifics of the loss of relativity affecting the MCP codes.

RPA’s comments on the 2021 proposed rule also highlighted to CMS that the same loss of relativity has likewise affected the inpatient dialysis codes and that the principle on which the outpatient dialysis code increase was based should be applied to the inpatient dialysis codes, but no change was made for the 2021 fee schedule. As a result, all four inpatient dialysis 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 \$68.06 for 2021, as compared to \$75.06 for 2020, an approximate 9.3% reduction in reimbursement.

In interventional care, the adverse effects of the CF reduction also apply to the dialysis circuit codes. For example, large volume CPT codes 36902 and 36905 (both balloon angioplasty services) each have RVU increases of 9% and 8%, respectively, as both services had a slight uptick in RVUs from the proposed rule to the final rule but because of the CF cut will experience payment reductions of 3% and 2%, respectively.

Conversion Factor

The bigger news across organized medicine in this rule regards the CF, and while CMS increased it from the proposed rule to the final rule by about \$00.15 to \$32.41 (\$32.26 was proposed), this only brings the overall reduction down to -10.1%, from -10.6% in the proposed rule (recalling that the 2020 CF was \$36.09). Thus, at press time, the 2021 Medicare fee schedule CF is set to be \$32.41, but this may not be etched in stone.

Evaluation and Management (E&M) Services

The value increases for E&M services first proposed in the 2020 rule, and newly proposed in August, have 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)—17% increase
- CPT code 99213 (level three office visit)—14% increase
- CPT code 99214 (level four office visit)—11% increase
- CPT code 99215 (level five office visit)—16% increase

If not upended by legislative changes before January 1, the **established patient E&M code reimbursement increases would be beneficial in the treatment of persons with CKD.**

CMS also finalized the addition of complexity add-on code G2211 (formerly referred to as GPC1X). G2211 is intended to account for “complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed healthcare services and/or with medical care services that are part of ongoing care related to a patient’s single, serious, or complex chronic condition.” CMS finalized total RVUs of 0.49 for this service, which would in many cases be appropriate to add to the underlying E&M code

in the context of providing care to complex CKD patients. It should be noted that the G2211 code is among the provisions that could be reversed if efforts to undo parts of the fee schedule are successful.

Additionally, CMS finalized the revised CPT descriptors and guidelines for implementation on January 1, 2021, which will be a significant modification to the coding and documentation for office visits. The final rule also includes positive news pertaining to the reduction of E&M documentation burden. As part of the proposed rule for 2020 and now finalized for 2021, CMS has indicated that: (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) history and physical documentation 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. (See the Coding Corner column on page 15 for more details on the E&M coding and documentation changes).

NCD for Apheresis

In the proposed rule, CMS outlined plans to remove National Coverage Determination (NCD) #110.14 for apheresis (Therapeutic Pheresis), developed in 1992. The Agency noted in the rule that this NCD predates the current NCD public notice standards and that no evidence review was published in support of the NCD. In our comments on the proposed rule, RPA acknowledged these concerns but urged CMS to embark on a public notice and review process that evaluates the current level of evidence for covering this service to account for patients who benefit from apheresis as well as the unpredictability of the Medicare Administrative Contractor (MAC) coverage process. CMS accepted RPA’s recommendation, stating in the final rule that they are going to take more time to consider the issues raised with regard to the apheresis NCD and will consider whether to propose removing the NCD in next year’s fee schedule rulemaking cycle.

Telehealth

While there was no major news on telehealth included in the final rule, CMS did create a new category 3 of telehealth services which “describes services added to the Medicare telehealth list during the public health emergency (PHE) for the COVID-19 pandemic (COVID-19 PHE) that will remain on the list through the calendar year in which the PHE ends.” In kidney care, ESRD MCP CPT codes 90952, 90953, 90956, 90959, and 90962 (mostly the single visit codes) were added to the list. RPA will continue to track the intersection of CMS telehealth policy and nephrology with the change in administrations and will keep membership apprised of key developments.

Quality Payment Program

Due to the pandemic, CMS limited the changes to the Quality Payment Program in 2021, which includes the Merit-based Incentive Program (MIPS) and Alternate Payment Models (APM). The rule also finalized 2020 QPP scoring flexibilities due to the PHE. CMS delayed the launch of MIPS Value Pathways from 2021 to 2022, but finalized a new reporting framework, the APM Performance Pathway (APP), to begin in 2021.

Merit-based Incentive Payment System (MIPS)

Category Weights

As expected, the rule finalized the following weights for each category of MIPS:

- Quality: 40% (down from 45% in 2020)
- Cost: 20% (up from 15% in 2020)
- Promoting Interoperability: 25% (no change)
- Improvement Activities: 15% (no change)

Reporting Threshold

CMS did not finalize the reduction of the MIPS performance threshold from 60 points to 50 points in 2021, despite comments from RPA and others in the community supporting the reduction. The exceptional performance threshold remains as 85 points; this is unchanged from 2020.

CY 2021 PFS Estimated Impact on Total Allowed Charges by Specialty

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact*
Allergy/Immunology	\$247	5%	4%	0%	9%
Anesthesiology	\$2,020	-6%	-1%	0%	-8%
Audiologist	\$75	-4%	-2%	0%	-6%
Cardiac Surgery	\$266	-5%	-2%	0%	-8%
Cardiology	\$6,871	1%	0%	0%	1%
Chiropractor	\$765	-7%	-3%	0%	-10%
Clinical Psychologist	\$832	0%	0%	0%	0%
Clinical Social Worker	\$857	0%	1%	0%	1%
Colon And Rectal Surgery	\$168	-4%	-1%	0%	-5%
Critical Care	\$378	-6%	-1%	0%	-7%
Dermatology	\$3,767	-1%	0%	0%	-1%
Diagnostic Testing Facility	\$748	-1%	-2%	0%	-3%
Emergency Medicine	\$3,077	-5%	-1%	0%	-6%
Endocrinology	\$508	10%	5%	1%	16%
Family Practice	\$6,020	8%	4%	0%	13%
Gastroenterology	\$1,757	-3%	-1%	0%	-4%
General Practice	\$412	5%	2%	0%	7%
General Surgery	\$2,057	-4%	-2%	0%	-6%
Geriatrics	\$192	1%	1%	0%	3%
Hand Surgery	\$246	-2%	-1%	0%	-3%
Hematology/Oncology	\$1,707	8%	5%	1%	14%
Independent Laboratory	\$645	-3%	-2%	0%	-5%
Infectious Disease	\$656	-4%	-1%	0%	-4%
Internal Medicine	\$10,730	2%	1%	0%	4%
Interventional Pain Mgmt	\$936	3%	3%	0%	7%
Interventional Radiology	\$499	-3%	-5%	0%	-8%
Multispecialty Clinic/Other Phys	\$153	-3%	-1%	0%	-3%
Nephrology	\$2,225	4%	2%	0%	6%
Neurology	\$1,522	3%	2%	0%	6%
Neurosurgery	\$811	-4%	-2%	-1%	-6%
Nuclear Medicine	\$56	-5%	-3%	0%	-8%
Nurse Anes / Anes Asst	\$1,321	-9%	-1%	0%	-10%
Nurse Practitioner	\$5,100	5%	3%	0%	7%
Obstetrics/Gynecology	\$636	4%	3%	0%	7%
Ophthalmology	\$5,343	-4%	-2%	0%	-6%
Optometry	\$1,359	-2%	-2%	0%	-4%
Oral/Maxillofacial Surgery	\$79	-2%	-2%	0%	-4%
Orthopedic Surgery	\$3,812	-3%	-1%	0%	-4%
Other	\$48	-3%	-2%	0%	-5%
Otolarngology	\$1,271	4%	3%	0%	7%
Pathology	\$1,265	-5%	-4%	0%	-9%
Pediatrics	\$67	4%	2%	0%	6%
Physical Medicine	\$1,164	-3%	0%	0%	-3%
Physical/Occupational Therapy	\$4,973	-4%	-4%	0%	-9%
Physician Assistant	\$2,901	5%	2%	0%	8%
Plastic Surgery	\$382	-4%	-3%	0%	-7%
Podiatry	\$2,133	-1%	0%	0%	-1%
Portable X-Ray Supplier	\$95	-2%	-4%	0%	-6%
Psychiatry	\$1,112	4%	3%	0%	7%
Pulmonary Disease	\$1,654	0%	0%	0%	1%
Radiation Oncology And Radiation Therapy Centers	\$1,809	-3%	-3%	0%	-5%
Radiology	\$5,275	-6%	-4%	0%	-10%
Rheumatology	\$548	10%	5%	1%	15%
Thoracic Surgery	\$352	-5%	-2%	0%	-8%
Urology	\$1,810	4%	4%	0%	8%
Vascular Surgery	\$1,293	-2%	-4%	0%	-6%
TOTAL	\$97,008	0%	0%	0%	0%

*Column F may not equal the sum of columns C, D, and E due to rounding.

From Capitol Hill

from page 1

the D’s pull the inside straight and do win both run-off races, it really would be a big now what moment for current Senate Majority Leader Mitch McConnell (R-KY) and his party.

In the House, Speaker Nancy Pelosi (D-CA) had her working majority reduced to a working-not-as-easily majority. In the current 116th Congress, the Democrats had a 35-vote margin, 232-197, with one libertarian seat and a few vacant. In the new 117th Congress to be sworn in early in January, the margin has been reduced, for the moment, to 13, 222-209, with four seats yet to be determined. Additionally, Speaker Pelosi will have to deal with competing forces within her own caucus, as the Blue Dog-ish moderates who believe they are responsible for the Democratic majority, no matter how big, have been intensely at odds with the Squad-ish progressive wing that presents itself as the voice of the future. All of that said, either way, it’s better to be in the majority, as the D leadership and committee chairs will get to set the agenda, have the power of the purse strings, and exercise oversight authority over everything else in Washington. But it’s not what it could have been, and Democrats are ruing a lost opportunity.

Of course, the Senate and the House are not the big news, since control of those chambers will maintain the status quo. The incoming Biden Administration would project to be about as polar opposite to that of the Trump Administration as can be imagined. First, it’s probably useful to level-set—generally, Democrats believe in the power of the federal government to do good for its citizens, while Republicans usually think that government is an obstacle to overcome on the path to success, however that is defined. Democrats seek to use the federal regulatory apparatus to level the playing field to ensure that all citizens have equal opportunities; in contrast, Republicans’ thought process is that the regulatory hoops are a bigger problem than the issues they seek to address and should be drawn back if not dismantled. As noted in this column previously, this dichotomy cuts both ways; for example, the undoing of administrative burdens has reduced E&M documentation burdens, thank God, but this can also lead to more rampant fraud and abuse in the Medicare program and other concerns.

As for what can be expected from a Biden Administration in terms of healthcare (a big now what), if the Obama experience is an indicator, there might be an influx of individuals with experience in the private sector or in government adjacent areas with interest in public service flocking to agencies like CMS, the FDA, or the Health Resources and Services Administration (HRSA, which is charged with improving access to healthcare services for marginalized patient populations). This is not always necessarily an entirely positive thing. For example, during the Obama Administration, there were idealistic Democratic Hill health staffers who thought that because they had read a lot of regulations, they could write regulations. Unfortunately, these skill sets are not the same, and there was a bit of a learning curve, although, of course, having committed people who care about what they’re doing is positive.

On policy, job #’s one, two, three, and up through probably 100, will be working on mitigating the devastating impact of the COVID-19 pandemic. Specific activities in this regard would include providing as much relief as possible to hospital systems and physician practices and making vaccine development, dissemination, and administration as seamless and comprehensive as possible, as quickly as possible. The guess here is that the PHE established last March and extended in 90-day intervals several times already will be extended at least

once more (it is currently scheduled to end on January 20, hmm, Inauguration Day, interesting). This would mean that the telehealth policies in place since the spring would stay in place. However, it is important to bear in mind that the major policy revisions, removing the originating site and geographic restrictions can only be done absent a PHE by Congress; there are efforts underway to enact legislation doing so, but this is by no means guaranteed.

Apart from that, President-Elect Biden will seek to restore those aspects of Obamacare that were rolled back by the Trump Administration, although this will be difficult without a Democratic majority in the Senate. Among the specific steps he would seek to take would be to establish a public option, lower the eligibility age for the program from 65 to 60, and provide more generous subsidies than currently available to increase participation, but achieving these objectives will be a heavy lift.

Otherwise, it’s reasonable to believe that there will be an effort to rebuild the status and effectiveness of Federal agencies such as the FDA and the CDC that have taken a bit of a reputational hit in recent years. In fairness to the outgoing administration, this dynamic is not entirely unique to them as, for example, the most recent other Republican administration (namely, that of President George W. Bush) also had a ‘starve-the-beast’ attitude to the federal bureaucracy. To be clear, this isn’t a judgment; they believed in smaller government and pursued it in this manner. That said, Twitter was not in wide usage during the Bush Administration (it was introduced in March of 2006), and even if it was, it’s hard to see the running commentary regarding the performance and priorities of federal agencies happening then as it has since 2016. The broader point is that the dance of Republican leadership seeking to downsize the federal government and Democratic successors seeking to expand it, or vice-versa, is pretty much how things work.

Back to Capitol Hill and legislating, the hope upon hope upon hope is that by the time you read this column, the immunosuppressive drug bill will have been enacted. In typical times one would observe that there’s really very little standing in the way of passage, as other bills need to be passed, the immuno bill saves money, there is germane legislation that is a ‘must-do’ priority (the Medicare Extenders bill), and there’s little disagreement on the merits. But not so fast, my friends. At press time, we’re at a point where government financing runs out on December 11, desperately needed COVID-19 relief has not been agreed upon, and even the National Defense Authorization Act, providing military funding and a sacred cow if there ever was one, is under threat because it includes language regarding guardrails on social media that is objectionable to President Trump. The current reporting is that there’s agreement on the top-level spending numbers for appropriations, and some daylight on COVID-19 relief, so maybe this will all come together and an extenders bill with the immuno provisions will be passed as well, but there are a lot of confounding factors.

So, as noted, we are at a big now what moment on so many issues--emerging on the other side of the pandemic, rebuilding the economy, and restoring a sense of normalcy to our nation after COVID-19. And while Mr. Biden’s ball might be on the rail in a difficult position, if the 2020 presidential campaign taught us anything, it’s that he is a skilled player who knows the angles, so he might be able to hold the table. Happy New Year. ■

2021 Medicare Fee Schedule

from page 5

Promoting Interoperability

The Query of Prescription Drug Monitoring Program measure will remain as an optional measure worth 10 bonus points. Additionally, a new optional Health Information Exchange (HIE) bi-directional exchange measure was added as an alternative reporting option to the two existing measures under the HIE objective.

MIPS Value Pathways

As previously reported, MIPS Value Pathways (MVPs) are a defined set of measures and activities under the MIPS program. CMS recognized the community’s concern over the development and implementation of a new reporting method in 2021. The rule finalized a set of guiding principles and delayed implementation of MVPs until 2022. RPA is

exploring the relevance of an MVP to nephrology, given that there are currently no nephrology measures in MIPS.

APM Performance Pathway (APP)

This new pathway is intended to be complementary to MVPs. The APP is available only to participants in MIPS APMs and can be reported by the individual eligible clinician, a group, or the APM Entity, therefore it is unclear whether it will have much impact on nephrology. The APP, like MVPs, is composed of a fixed set of measures for each performance category.

Additional information on the QPP program may be found at <https://www.renalmd.org/page/physiciandevelopment>. ★■



Webinars Deliver Robust, Timely Policy, Leadership Content

The Fall 2020 RPA PAL webinar series brought nephrology professionals the latest information on policy changes and their implications for nephrology practice. The series kicked off on October 30, with the webinar “Insights into the Kidney Payment Models: What Nephrologists Need to Know.” The webinar featured Terry Ketchersid, MD, MBA, RPA Board member and CMO, Integrated Care Group, Fresenius Medical Care, and Alexander Liang, MD, President and CEO of Dallas Nephrology. RPA President-Elect, Timothy Pflederer, MD, moderated the session. Drs. Ketchersid and Liang provided the latest information on the mandatory ESRD Treatment Choices (ETC) Model, which includes a random selection of practices, stratified by region of the country, beginning January 1, 2021. The webinar addressed the ETC’s two financial Incentives: Home Dialysis Payment Adjustment (HDP) and Performance Payment Adjustment (PPA) and scoring methodology. Drs. Ketchersid and Liang also reviewed requirements contained in the voluntary Kidney Care First (KCF) model, which will begin April 1, 2021. They addressed beneficiary eligibility and payment types: quarterly capitated payment, adjusted MCP, and the kidney transplant bonus.

On November 18, Jeff Stevey, senior director of joint ventures, mergers, and acquisitions at Fresenius Medical Care presented, “Mitigating Ideology Differences Through Communication,” which focused on the leadership component of PAL. Nishant Jalandhara, MD, vice-chair of RPA PAL and member of the RPA Board of Directors, moderated the session. Mr. Stevey explored how the role of identity, social identity theory, and more can be used to improve collaboration in decision-making between administrators and nephrologists and how it can lead to better physician engagement. He discussed how drawing

on the nephrologists’ problem-solving skills and expertise and the administrator’s understanding of organizational needs and policies can lead to more constructive relationships and better patient care.

The RPA PAL webinar series pivoted to a panel discussion on “Optimal CKD Care” on December 3. RPA Board members Shaun Conlon, MD (Atlanta Nephrology Associates), Katherine Kwon, MD (Lake Michigan Nephrology), and Rajiv Poduval, MD (Southwest Kidney Institute), served as the panelists, and Harry Giles, MD, chair of RPA PAL and RPA Board member moderated this webinar. Providing the perspective of both small and large nephrology practices around the country, the panelists shared how they manage CKD patients, including the use of chronic care management codes, principal care management codes, and TCM codes. They shared tips for creating efficient programs, billing requirements, and how to assess practice capacity for such programs.

The 2020 webinar series concluded on December 10, with “Update on Revised E&M Coding Structure for 2021” featuring Adam Weinstein, MD, RPA’s representative to the AMA Relative Value Update Committee and RPA registry workgroup chair. Dr. Weinstein provided the context within which the E&M changes came about, as well as a thorough explanation of the changes for CPT codes 99202-99205 and 99212-99215.

All webinars from the 2020 RPA PAL series were recorded and are available for on-demand viewing on RPA’s eLearning platform (<https://rpa.mycrowdwisdom.com/diweb/start>). Check renalmd.org for more information about RPA’s 2021 webinars and events. ☆■

PAID ADVERTISEMENT

A CLINICAL RESEARCH STUDY FOR ADULTS OF AFRICAN, LATIN AMERICAN, OR CARIBBEAN DESCENT



If you have a patient with kidney disease, this clinical research study may be an option.

Eligible participants must meet the following criteria:

- Be male or female adults of African, Latin American, or Caribbean descent between the ages of 18 and 60 (inclusive)
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- Have an apolipoprotein L1 (APOLI) genotype (patients will be tested for this genotype variation during screening visit if needed)

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RPA Creates Smart Form Based on Nephrology Quality Measures

The need for an easily usable standard set of clinical metrics describing patients’ CKD to ESRD progression has been one of the goals of RPA’s Registry workgroup. The workgroup, which oversees RPA’s registry platform and Quality Clinical Data Registry (QCDR), has developed and curated several nephrology-specific quality measures since 2015. However, the QCDR functionality of the RPA Registry has struggled with interoperability hurdles and CMS’ strategic departure from custom quality measures. In partnership with Epic and Epic’s nephrology steering committee, the RPA now has a clear path forward to overcome these hurdles.

In late 2018, RPA’s registry workgroup decided to develop universally applicable CKD to ESRD quality measures, addressing a significant gap in the nephrology measurement space. These metrics provide numerator, denominator, and exclusion definitions for a series of six metrics addressing CKD education, modality education and selection, access surgeon referral, access placement, and transplant listing. While workgroups initially intended to publish these as non-reportable measures in the RPA’s QCDR, ongoing work with Epic offered a more robust venue for deployment.

Over the last few years, Epic has convened several specialty-specific steering committees to help include richer specialty functionality and content in Epic’s foundation system – a suggested setup using the standard Epic tools. Epic’s nephrology steering committee enjoys broad representation from the renal community, including several RPA members who serve on the registry workgroup. This cross-pollination of workgroup members facilitated the introduction, development, and deployment of the RPA measures as part of the May 2020 release of the Epic foundation system. Specifically, the metrics are now part of a Smart Form, which allows for a standardized set of data capture within Epic’s documentation workflow. As such, when an Epic-using organization upgrades to the May 2020 version, the tools for capturing and using the RPA metrics are accessible.

The Smart Form (below) was developed for nephrology practices seeing CKD patients in the office setting. Using the Smart Form during an office encounter, the user can quickly capture specific data for each measure. As such, Epic’s CKD Smart Form facilitates a standard location and vocabulary for these data, a significant advantage for later aggregation and reporting.

It also allows users to aggregate and analyze the data within Epic’s reporting workbench. The reporting workbench also provides a means for data to be output in standard formats, such as Excel or CSV, for further data manipulation and analysis. Such data may be helpful to those practices participating in either the ETC or KCF payment models, as practices will need clearly defined processes in order to meet the models’ outcome measures.

The RPA registry workgroup is pleased to be able to provide this resource to nephrology practices. Evan Norfolk, MD, a nephrologist at Geisinger Medical Center and member of both the RPA Registry workgroup and Epic nephrology steering committee, noted, “We are grateful to Epic for the collaboration. I think we all recognize the need to have standardized data for these typical CKD-related activities. I think members of both committees see the potential to leverage Epic’s technology and scale combined with the RPA’s expertise in quality measure development.”

Epic’s May 2020 foundation system update included the CKD smart form. Interested users will need to work with their institution’s Epic deployment and configuration team to determine their Epic version and, if appropriate, make these new tools available for users. Specifically, you should ask your Epic IT support team to see Epic note on the Epic “galaxy” website. Questions about the Smart Form should be directed to abeckrich@renalmd.org. ■

CKD Smart Form:

CKD Education

Status:referredcompleted

Comments

Definition/Purpose

During the encounter the patient is instructed about one or more of the following: the etiology and prognosis of their CKD; the stability (or lack thereof) of their eGFR or CrCl; medication dosing, IV contrast avoidance, or specific medications to avoid; sodium, potassium, or phosphorus restriction (or other dietary counseling). Referral to an educator or program that offers any CKD-specific counseling is applicable. Having completed education in the previous 12 months to the encounter date is also applicable.

Modality Education

Status:referredcompletednot a candidate

Comments

Definition/Purpose

During the encounter the patient is directly counseled and/or referred to education regarding the options for dialysis including in-center, home therapies, transplant, and/or hospice. Patients who are at low risk of progression (by various risk calculators) may be deemed "not a candidate." Completion of education in the past is also applicable.

Preferred Modality

Status:hemodialysisnocturnal hemodialysisperitoneal dialysis
home hemodialysisnot a candidate

Comments

Definition/Purpose

During the encounter the patient indicates that they have chosen a modality of dialysis, irrespective of the estimated time to ESRD. The goal of this measure is to reflect education and understanding. This may change visit to visit as the patient’s health status and other conditions dictate. "Not a Candidate" should be selected for patients choosing hospice, are at low risk for progression (based on various scoring and/or clinician judgment), or for other medically documented exclusion.

Access Surgeon Referral

Status:referrednot a candidate

Comments

Definition/Purpose

This measure indicates that the patient has been referred for discussion and/or evaluation by a dialysis access surgeon. "Not a Candidate" should be selected for patients choosing hospice, are at low risk for progression (based on various scoring and/or clinician judgment), or for other medically documented exclusion.

Access Placed

Status:AV fistulaAV graftperitoneal dialysis
central venous cathetersurgery schedulednot a candidate

Comments

Definition/Purpose

This measure indicates that the patient has undergone surgery for dialysis access placement. "Not a Candidate" should be selected for patients choosing hospice, are at low risk for progression (based on various scoring and/or clinician judgment), or for other medically documented exclusion.

Transplant Listing

Status:referrednot eligiblenot on list

Comments

Definition/Purpose

This measure indicates that the patient has actively engaged in the transplant listing process. "Not Eligible" should be selected for patients choosing hospice, are at low risk for progression (based on various scoring and/or clinician judgment), or for other medically documented exclusion.

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RPA's 2021 Annual Meeting Arrives in Your Home/Office in March

By Gary Singer, MD, Education Committee Chair



Are you confused by the new CKD payment models? Did you recently complete your nephrology fellowship or join a group practice? Does COVID-19 make you anxious and did the pandemic affect your delivery of quality kidney care? What is #NephTwitter and what's a hashtag?

If you want answers to these questions and many more, register for the 2021 RPA Annual Meeting. This is such an exciting time to be caring for patients with kidney disease, and this meeting will have speakers and topics that will

appeal to everybody. Dr. Jeffrey Perlmuter, RPA President, will provide a review of 2020 – a year that nobody will forget. RPA health policy guru, Robert Blaser, will deliver a legislative update, addressing issues of importance to all nephrology practitioners.

We have an exciting panel of speakers to help early-career nephrologists better understand practice management, navigate contract negotiations, and learn about the finances of dialysis clinics. They will also have opportunities to network and connect with mentors to help guide them.

While the Advancing American Kidney Health (AAKH) Executive Order was signed during the summer of 2019, the new models of CKD care are just being rolled out. We will have experts review the payment schemes and describe how these will affect your practice. The AAKH initiative also includes an expansion of home dialysis and transplantation. Leaders in these areas will show you how to grow a successful peritoneal dialysis and home hemodialysis program. In addition, we will explore ways to increase the pipeline of kidneys available for transplantation. None of this will be achievable without patient engagement, and we are fortunate to have Kevin Fowler, kidney transplant recipient and patient advocacy

expert, to help us understand how we can better involve patients in their care.

Over the past several years, there has been an explosion of novel teaching methods as well as free and open access to medical information via social media. Twitter and its role in nephrology education and sharing of knowledge will take center stage at the meeting. Dr. Joel Topf, better known as @kidney_boy, will headline a panel of distinguished speakers, focusing on why you should be on Twitter (if you aren't already).

The COVID-19 pandemic has impacted everybody, especially our patients and our ability to care for them. We have also seen an expansion in the adoption of telehealth in nephrology practices and dialysis clinics. There will be sessions covering these topics as well as the effect of the PHE on the wellbeing of healthcare workers.

We have specially designed meeting tracks focused on helping Advanced Practitioners enhance their leadership skills as well as a Business Management pathway with tips and tools for practice administrators.

Some of our sessions will be presented in the form of panel discussions with such diverse and important topics as the social determinants of health and disruptive innovation in the care delivery models.

The meeting will close with a whirlwind literature review, an overview of innovations, and discussions of new and exciting treatment options for patients with kidney disease—SGLT2 inhibitors and HIF-PH inhibitors.

No need to book a flight or make airline reservations. Just register at www.renalmd.org. I encourage you to block the time on your schedule so you can fully engage in this dynamic program. This is a great opportunity to reconnect with colleagues, make new friends, find mentors, learn how to provide the best care for your patients, and be a better advocate. Follow the RPA on Twitter at @RPANephrology and use the hashtag #RPA21 for our virtual Annual Meeting, March 18-20, 2021. “See” you there! 🌟■

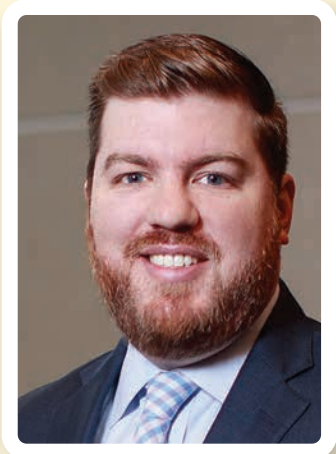


Public Policy News Briefs

- ▶ On December 2, CMS released the final rule for the **Hospital Outpatient Prospective Payment and Ambulatory Surgical Center (HOPPS/ASC) Payment Systems**, which addressed two issues of importance to nephrology. First, CMS, in its proposed rule from this summer, solicited comment on whether the two balloon angioplasty codes, CPT codes 36902 and 36905, should have a permanent exemption from the office-based designation (this is what caused the proposed drastic cuts in recent years that were never finalized). RPA urged CMS to provide the permanent exemption, and while CMS decided not to do this, it was because they believe the utilization threshold that would trigger such a move will never be met, and the initial data in this area supports their decision. Second, CMS proposed to move service code G2170 for percutaneous arteriovenous fistula (pAVF) creation (representing thermal creation of a pAVF) down one ambulatory payment classification (APC), with a corresponding substantial cut in reimbursement. RPA urged the Agency to defer on making such a change, as we believed it was based on limited data, and CMS agreed and will not change the APC category for G2170 for 2021. More broadly, CMS is increasing reimbursement for outpatient hospitals and ASCs by an overall 2.4% in 2021 and is finalizing its proposal to eliminate the Inpatient Only List procedure over the course of three calendar years.
- ▶ On November 20, CMS and the Office of Inspector General (OIG) for HHS finalized two rules with applications for physicians' financial arrangements in the era of value-based care and coordinated services. CMS issued the final rule on the **physician self-referral (Stark) law**, which is highlighted by a proposal to protect value-based arrangements in which the entity takes on either full or substantial financial risk, or where care coordination arrangements are made to improve quality and efficiency of care delivery. In the OIG's final rule for the **anti-kickback statute (AKS)** and civil monetary penalties (CMP), several new safe harbors were provided, including new flexibilities in the area of Personal Services (RPA called for changes in this area in our December 31, 2019, comments on the proposed rule) and with regard to Local Transportation, where the mileage limit for patients living in rural areas was extended from 50 to 75 miles (RPA called for the limit to be extended to 100 miles).
- ▶ On November 20, CMS released its final rule updating the **CFCs for Organ Procurement Organizations (OPOs)**. The rule acted on several recommendations made by RPA in our comments on the proposed rule, including its plans to use comparative donation rates and organ transplantation rates relative to the highest-performing OPOs nationally (defined as the highest performing 25 percent of OPOs) to benchmark success for other OPOs and to institute an annual 12-month performance review period.
- ▶ On November 10, RPA joined the AMA and other organized medicine groups in calling on Medicare and a broad group of private payers to provide coverage for the new **CPT code 99072**. This code is to be used to report the additional supplies, materials, and clinical staff time over and above the practice expense(s) included in an office visit or other non-facility service(s) when performed during a PHE, as defined by law, due to respiratory-transmitted infectious disease. In addition to Medicare, separate letters were sent to America's Health Insurance Plans, Blue Cross Blue Shield Association, and major commercial health plans (i.e., Anthem, Aetna, Cigna, Health Care Service Corporation, Humana and UnitedHealthcare) urging them to immediately implement and pay for CPT code 99072.
- ▶ On November 2, CMS released the final rule for the **2021 ESRD Prospective Payment System (PPS)**, and set the 2021 base rate at \$253.13, for both in-center dialysis and for acute kidney injury (AKI) services; by law, the AKI rate must be equal to that of in-center patients. \$9.93 of the increase was due to calcimimetics. Additionally, they reduced the interval for which calcimimetics will be calculated from 2 years to 18 months (beginning with the third quarter of 2018 and all of 2019). RPA recommended only using 2019, so they came halfway on our recommendation to not use 2018 data. CMS projects that the updates for CY 2021 will increase the total payments to all ESRD facilities by 2.0 percent compared with CY 2020. For hospital-based ESRD facilities, CMS projects a decrease in total payments of 0.2 percent, while for freestanding facilities the projected increase in total payments is 2.0 percent. ■

Legal Issues: Guidance for Recipients of Provider Relief Fund Payments

By Kimberly J. Kannensohn and Colin P. McCarthy



As most of you know, the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), a \$2.2 trillion stimulus bill that was signed into law on March 27, 2020, provided \$100 billion for “healthcare-related expenses or lost revenues that are attributable” to the 2019 novel coronavirus (COVID-19) pandemic. This appropriation, referred to as the Public Health and Social Services Emergency Fund (Provider Relief Fund), was supplemented with an additional \$75 billion pursuant to the Paycheck Protection Program and Health Care Enhancement Act, signed into law on April 24, 2020. The purpose of the Provider Relief Fund was to distribute funds “... to prevent, prepare for, and respond to coronavirus, domestically or internationally, for necessary expenses to reimburse, through grants or other mechanisms, eligible healthcare providers for healthcare-related expenses or lost revenues that are attributable to coronavirus.”

Nephrologists qualify as eligible providers for the receipt of funds under the CARES Act and the supplemental funding legislation. A nephrology practice may have received Provider Relief Fund payments as part of either the “General Distribution” tranche or various “Targeted Distributions.” As a condition of receiving payments from the Provider Relief Fund, eligible providers were required to attest to the terms and conditions of the Provider Relief Fund (Terms and Conditions), which require, among other things, that providers certify that the payment “will only be used to prevent, prepare for, and respond to coronavirus” or to reimburse the provider “for healthcare-related expenses or lost revenues that are attributable to coronavirus.” The Terms and Conditions also require that recipients of Provider Relief Fund payments submit such reports as directed by the Secretary of the U.S. Department of Health and Human Services (HHS). Accordingly, nephrology practices that received Provider Relief Fund payments must comply with the reporting requirements and deadlines described in this article.

Reporting Requirements

On October 22, 2020, HHS issued its Post-Payment Notice of Reporting Requirement (Notice), which details reporting requirements for healthcare providers that have received one or more Provider Relief Fund payments exceeding \$10,000 in the aggregate, regardless of the timing of the payment or whether the payment was part of the General Distribution, the Targeted Distribution, or both.

Reporting Deadlines

The portal for reporting usage of funds is expected to open on January 15, 2021, with the initial report due by February 15, 2021. Recipients that have not expended the full amount of Provider Relief Fund payments during the calendar year 2020 have an additional six months to use any remaining amounts. Those providers must submit a final report by July 31, 2021, that includes patient care-related revenue amounts earned during the period from January 1, 2020, through June 30, 2021.

Parent Entities Can Report for Consolidated Entities in Many Situations

For general distributions, in most cases, parent entities can direct the funds amongst their subsidiaries, and report on the same. For targeted distributions, such as the amounts provided to hospitals with significant COVID-19 admissions, the subsidiary entity must report on its use of funds. HHS reiterated its past guidance that parent companies cannot utilize funds intended for providers that were sold in an asset deal.

Required Data

Recipients are broadly required to report (using their normal method of accounting, whether cash or accrual) the following:

1. Demographic Information

Specifically, the name of the recipient and the recipient’s TIN, NPI (optional), fiscal year-end date, and federal tax classification.

2. Healthcare-related Expenses Attributable to the Coronavirus not Reimbursed by Other Sources.

a. Providers that Received Between \$10,000 and \$499,999 in the Aggregate

Providers that received between \$10,000 and \$499,999 in the aggregate from the Provider Relief Fund must report healthcare-related expenses attributable to COVID-19 net of other reimbursed sources in two categories: (i) general and administrative expenses; and (ii) other healthcare released expenses. HHS considers these the actual expenses incurred over and above what has been reimbursed through other sources.

b. Providers that Received \$500,000 in the Aggregate or More

Providers that received \$500,000 in the aggregate or more from the Provider Relief Fund must report their healthcare-related expenses in the same two categories and must also include the following subcategories of expenses:

i. General and Administrative Expenses:

1. Mortgage and Rent: Monthly payments related to mortgage or rent for a facility.
2. Insurance: Premiums paid for property, malpractice, business insurance, etc. relevant to operations.
3. Personnel: Workforce-related actual expenses paid to prevent prepare for, or respond to COVID-19, such as training, staffing, temporary employee or contractor payroll.
4. Fringe Benefits: Extra benefits supplementing an employee’s salary, including hazard pay, travel reimbursement, and employee health insurance.
5. Lease Payments: New equipment or software lease.
6. Utilities/Operations: Lighting, cooling/ventilation, cleaning, or additional third-party vendor services.
7. Other General and Administrative Expenses: Costs not captured above that are generally considered part of overhead structure.

ii. Healthcare-Related Expenses Attributable to COVID-19:

1. Supplies: Expenses paid for purchase of supplies used to prevent, prepare for, or respond to COVID-19, including PPE or hand sanitizer.
2. Equipment: Expenses paid for purchase of supplies used to prevent, prepare for, or respond to COVID-19, including ventilators and updates to HVAC systems.
3. Information Technology (IT): Expenses paid for IT or interoperability systems to expand or preserve care delivery during the reporting period, including electronic health record licensing fees, telehealth infrastructure, etc.
4. Facilities: Expenses paid for facility-related costs used to prevent prepare for, or respond to COVID-19, including the lease or purchase or permanent or temporary structures, or to modify facilities to accommodate patient practices due to COVID-19.
5. Other Healthcare Related Expenses: Expenses not captured above that are generally considered part of overhead structure.

c. Additional Instruction Related to Healthcare-related Expenses Attributable to the Coronavirus not Reimbursed by Other Sources

HHS defines “healthcare-related expenses attributable to the coronavirus” to include expenses “incurred both in treating confirmed or suspected cases of coronavirus, preparing for possible or actual coronavirus cases, maintaining healthcare delivery capacity, etc.” In the Notice, HHS clarified that providers need to offset direct patient billing, commercial insurance, and government healthcare reimbursement for such expenses. HHS provided instructions for providers on how to apply such reimbursement in its Frequently Asked Questions (FAQs). According to HHS, providers should first “apply reasonable assumptions when estimating the portion of [expenses] that are reimbursed from other sources.” Second, providers should use the “marginal increased expenses related to coronavirus” per each patient visit. HHS gave an example of a provider with pre-pandemic expenses of \$80 per patient visit rising by \$5 per visit. In such circumstance, unless a third-party insurer reimbursed additional funds for COVID-19, a provider could record \$5 per visit as an increased expense, regardless of how much the provider actually received from a patient or third-party source (e.g., if Medicare paid \$70 per visit and the commercial insurer paid \$100 per visit, it would still be recorded as \$5 per visit in increased expense in both cases).

d. General and Administrative Expenses Also Must Be Incremental Expenses

For general and administrative expenses, HHS instructed that Provider Relief Funds should be used only for incremental expenses or those “expenses incurred that were attributable to coronavirus,” and indicated that providers must offset expenses incurred with other sources covering those expenses. HHS gave a specific example of a provider with \$1,000 in personal protective equipment (PPE) costs in 2019 that increased by \$3,000 in 2020 (and if some of that was incurred as a result of the expansion of services, that could not be included as a general or administrative expense as it would not be attributable to COVID-19). Providers would then need to “apply reasonable assumptions” to reduce this amount based on other assistance received, including third-party reimbursement. Other potential general and administrative expenses to calculate prior to offset could include “hiring additional security personnel, increased hazard pay, increased cost of utilities to operate temporary facilities, or similar items ... not normally incurred.”

e. Employee Expenses Entail a Similar Two-Step Process

HHS also issued guidance regarding reporting of employee costs. Providers should first total the amount paid for workforce-related actual expenses paid to prevent, prepare for, or respond to the coronavirus during the reporting period, such as workforce training, staffing, temporary employee or contractor payroll, overhead employees, or security personnel, capping compensation at the Executive Level II cap (or \$197,300), exclusive of fringe benefits and indirect costs. Second, providers should determine whether any other reimbursement, including FEMA grants and commercial insurance, should be reasonably applied to this amount to reduce the reported number. Only after implementing these two steps may providers include the balance on the final report to count towards its Provider Relief Fund payments. With respect to the Executive Level II cap, HHS reinforced its position that the limitation applies only to the rate of pay charged to Provider Relief Fund payments and “other” HHS awards. Organizations may pay their employees above the salary cap with non-federal funds.

3. Lost Revenues Attributable to the Coronavirus

Providers must report lost revenues attributable to the coronavirus, but only to the extent that the applicable Provider Relief Fund payments have not been fully expended on the healthcare-related expenses attributable to the coronavirus described in item 2. While initial guidance from HHS indicated that lost revenues would be defined as “negative change in year-over-year *net operating income* from patient-related sources” (emphasis added), the updated Notice reversed that profit-based calculation and allows recipients to apply Provider Relief Fund payments toward lost revenue, “up to the amount of the difference between [a recipient’s] 2019 and 2020 actual patient care revenue.”¹

Specifically, all recipients of more than \$10,000 in aggregate Provider Relief Fund payments must report:

- a. **Total Revenue/Net Charges from Patient Care Related Sources**, which is defined as net of uncollectible patient service revenue recognized as bad debts and prior to netting with expenses, broken down into:
 - i. Actual Revenue/Net Charges received from the following Patient Care Payers in 2019 and 2020;
 - ii. Medicare Parts A+B;
 - iii. Medicare Part C;
 - iv. Medicaid;
 - v. Commercial Insurance;
 - vi. Self-Pay (no insurance); and
 - vii. “actual gross revenues/net charges from other sources received for patient care services and not included in the list above for the [applicable] calendar year.”
- b. **Other Assistance Received** from the following sources in 2020 alone:
 - i. Treasury;
 - ii. Small Business Administration (SBA) and the CARES Act/ Paycheck Protection Program (PPP);
 - iii. FEMA CARES Act;
 - iv. CARES Act Testing;
 - v. Local, State, and Tribal Government Assistance;
 - vi. Business Insurance; and
 - vii. The “total amount of other federal and/or coronavirus-related assistance received by the recipient and the other TINs included in its report as of the reporting period end date.”
- c. **Total Calendar Year Expenses**, broken down by calendar year quarters into:
 - i. General and Administrative Expenses in 2019 and 2020, including monthly payments related to mortgage or rent for the facility where the Reporting Entity provides patient care services; other monthly finance charges for real property and/or property taxes; insurance premiums for property; employee health insurance; malpractice insurance; overhead salaries; healthcare and contractor salaries; fringe benefits; lease payments; lighting, cooling/ventilation, cleaning, vendor services purchased from third party vendors; consulting support; legal fees; audit and accounting services; food preparation and supplies; logistics and transport; and other costs not otherwise captured, such as debt financing, for the relevant calendar year; and
 - ii. Healthcare-Related Expenses in 2019 and 2020, including supplies, equipment, IT, facilities, employees, and other healthcare related costs/expenses for the relevant calendar year.
4. **Additional Non-financial Data (per quarter)**, specifically, (a) facility, staffing, and patient care information, (b) change in ownership information, and (c) single audit status.

Accrued Interest Must be Returned or Reported

HHS answered multiple questions in its FAQs regarding interest earned on Provider Relief Fund amounts. If a recipient is required to return funds to HHS (perhaps due to not being able to report appropriate use of all funds received) after those funds were held in an interest-bearing account, HHS must receive that interest, too. All returns of Provider Relief Funds to HHS will be subject to audits for accrued interest. There is, however, no requirement to hold Provider Relief Fund payments in an interest-bearing account, so interest will not be required on returned funds the recipient held in a non-interest-bearing account. For recipients retaining Provider Relief Fund payments, any interest earned on such funds will be reported as “other assistance received,” and should be reported as operating revenue.

Records Must be Kept for a Minimum of Three Years

HHS will not require providers to submit supporting documentation with the final report. However, HHS clarified that according to 2 C.F.R. 200.333, each recipient is required to retain original

Continued on page 12

¹ HHS defines “lost revenues attributable to the coronavirus” as a negative change in year-over-year actual revenue from patient care related sources, net of the healthcare related expenses attributable to the coronavirus described in the preceding section. HHS, in turn, defines “patient care” as “healthcare, services and support, as provided in a medical setting, at home, or in the community,” excluding “(1) insurance, retail, or real estate values (except for SNFs [and assisted living facilities], where that is allowable as a patient care cost), or (2) grants or tuition.”

For Early Career Nephrologists: Looking Forward to the New Year

By Shaun Conlon, MD



I am writing this article the week after Thanksgiving. I spent last week rounding on hospital patients, including multiple ones with COVID-19. Instead of the typical gathering with 15 to 20 family members for Thanksgiving, I spent the holiday at home with only my wife and two children (who thankfully are all healthy). No one could have predicted what a tumultuous year 2020 was, with a global viral pandemic, unrest regarding racial inequalities, and a contentious election. Living in Georgia, I will have to endure several

more weeks of negative political advertisements given the upcoming dual Senate runoff elections in January that will decide control of that chamber. Despite all of this, I am hopeful for the new year, both in general and for nephrology specifically.

New Value-Based Care Models

My group has participated in the ESCO model since 2017. It has been a good learning experience for us in value-based care. We have learned to coordinate our efforts not only with a large dialysis organization but also with several other nephrology groups in our area. We have gained valuable insights as to what drives the cost of care in our ESRD patients and then worked to develop creative solutions to lower those costs. We also have worked to optimize the quality of our care, through reduction of admissions/re-admissions, reduction of central venous catheters, and increases in treatment compliance.

We will transition from the ESCO model to the CKCC model in 2021. Undoubtedly, we will focus on many of the same issues as in the ESCO model, but we will need to tackle new challenges. Not only will we need to aggregate data about our ESRD patients, but we will need to include our CKD stage 4 and 5 patients as well. It will be interesting to learn what drives the cost of care in the CKD population as it will likely be different than the drivers in the ESRD population. We will have an increased focus on transplantation and likely take a more active role in shepherding our patients through the transplant evaluation process. We will have to focus on patient activation (I'm still learning what this means) and mental health (as depression is a quality measure for the program).

Emerging Therapeutics for Renal Disease

Since I completed my fellowship in 2012, there have been multiple new therapeutics available to our patients, and I expect several more to be available in 2021. I now have several additional options for phosphorus binders, though I am hopeful for approval of a drug with a new mechanism of action to treat hyperphosphatemia. Instead of episodic treatment of hyperkalemia with a decades-old drug that isn't safe for chronic use, I now have two drugs that lower potassium and allow my

patients to stay on other important medications such as ACE inhibitors, ARBs, and aldosterone antagonists. When the SGLT2 inhibitors were first approved, I remember one of my partners questioning why one would want to start a drug that caused glycosuria. I was unprepared for the overwhelming positive benefit of this class of drugs, both for nephropathy and also for cardiovascular disease. I am hopeful for the approval of a new class of drugs to treat anemia in CKD patients – this will be the first new option for this problem in decades. It is exciting for our patients to have an option for an oral medication rather than an injection.

A Different Political Environment

I think most would agree regardless of political leaning that this election season was particularly contentious and stressful. I am saddened that much of the rhetoric from politicians from both sides is focused not on what they have done and can do for their constituents but rather why their opponent is the wrong choice. Voters did not hand one party a decisive majority last month, and that means they are asking for the two sides to work together and compromise on issues. I hope that with the election behind us in early 2021, we might see some legislation advanced that comes from a civilized discourse between the two sides and that will benefit all Americans.

Tempering of the Pandemic

Most important for 2021, I am looking forward to a semi-return to normalcy by the end of the year. I expect there will be several vaccines approved by the time you read this, and if all goes well, many of you will have already received one or two doses of a vaccine. I am looking forward to a summer when I can bring my two young children to visit their grandparents in New York and not have to worry about infecting them (and not have to quarantine upon arrival for two weeks). I look forward to holidays in late 2021 when I can again gather with family and friends and not worry that the gathering will be a superspreader event. I am waiting for a new passport to arrive in the mail – I hope to be able to use this soon to travel to exciting international destinations.

Unfortunately, I will not be able to see any of you in person in March at the Annual Meeting as it will be virtual this year. Although a June Washington Weekend in person seems like wishful thinking, a 2022 Annual Meeting in person seems quite likely at this point. I look forward to gathering with many of you again in person and sharing stories of how we got through this difficult time, both personally and professionally. ■

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.

Legal Issues

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documentation with respect to its participation in the Provider Relief Fund for three years after submitting the final report.

This article summarizes the reporting obligations, deadlines, and recordkeeping requirements applicable, as of December 2020, to nephrologists and nephrology practices who received Provider Relief Fund payments. As the healthcare system continues to be impacted by the COVID-19 pandemic, additional funding may be made available through new legislation, accompanied by new or modified reporting requirements and deadlines.

HHS, Post-Payment Notice of Reporting Requirements (Sep. 19, 2020) is available at <https://www.hhs.gov/sites/default/files/post-payment-notice-of-reporting-requirements.pdf>.

HHS, Post-Payment Notice of Reporting Requirements (Oct. 22, 2020) is available at <https://www.hhs.gov/sites/default/files/post-payment-notice-of-reporting-requirements-october-2020.pdf>.

HHS, Reporting Requirements Policy Update (Oct. 22, 2020) is available at <https://www.hhs.gov/sites/default/files/reporting-requirements-policy-update.pdf>.

CARES Act Provider Relief Fund: FAQs are available at <https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/faqs/index.html>. ■

Ms. Kannensohn is a partner in the McGuireWoods Healthcare Practice and counsel to the Renal Physicians Association. Mr. McCarthy is a senior counsel in the McGuireWoods Healthcare Practice who regularly advises clients on Provider Relief Fund questions.

AUTHOR'S NOTE: *This article is for information purposes only and not for providing legal advice. You should contact your attorney and/or tax advisor to obtain advice with respect to any particular issue or problem. The opinions expressed at or through this article are the opinions of the individual authors and may not reflect the opinions of the firm or any individual attorney.*



PRACTICE MANAGEMENT

A Year Like No Other

By Stacey Loomis, CMPE



Does anyone else feel like they have just been through the biggest test of their lives - a long, brutal test for which there was no preparation? As practice managers, people rely upon us daily for any number of things. Honestly, how many different things did you have to re-invent, tweak, adjust, or simply make up as a practice manager in the past year? From financing and staffing issues and implementing a telehealth platform within a few days to re-vamping your waiting rooms, workflows, and office

space, nothing we did was unaffected by the pandemic.

In preparation for writing this article, I re-read the January 2020 practice management column written by my idol, Jennifer Huneycutt: *Seven Tips to Make 2020 Your Best Year Yet*. I have to say that even though we all felt like our carefully laid plans were down the drain as early as February, in some respects, we may have actually had our best year yet. There was no time for inaction. We were nimble and adaptive and brought our practices with us. We masked up, drew from our experience, collaborated with our peers, shared information and recommendations, flexed our muscles, and made it work. You should definitely add crisis manager to your resume. You have earned it!

The number of resources available to us is vast and growing. And thank goodness, as we now know that we must be ready for anything and everything. We should rely on these to help us and look upon them as tools in our arsenal. I asked around for tips to see where people look for reliable information about all aspects of practice management, not just the pandemic. Here are some of the resources that were mentioned:

The RPA. On St. Patrick's Day last year, we heard from Rob Blaser in an email about Medicare's decision to lift many previous restrictions on telehealth. That document became our bible as we navigated the largely uncharted waters of telehealth. I was so happy to be able to send my numerous questions and get timely answers from the experts at RPA who care about our practices and focus specifically on the nephrology specialty. Their ongoing updates and explanations of new laws and Billing & Coding Seminars continue to provide guidance on coding and reimbursement for our practices.

Our payroll companies. They provide much more service than just running payroll and delivering W-2 forms. They can provide canned and custom reports to help with loan forgiveness applications and planning. They can also help with understanding the legal requirements in your state. Are you required to pay an employee on quarantine? Your payroll company will know if you are and how to code that properly so that you get the best tax benefits. Their expertise is available to their clients, and we should be taking advantage of that.

The MGMA member communities and website. There was a member community formed about COVID-19 almost immediately that had oodles of followers and contributors from all corners of our industry. Administrators, HR specialists, public health administrators, and attorneys weighed in on any question you could pose. It was great to see that we are all dealing with the same issues, and the sharing of information on this platform made us see that we weren't alone. There are communities devoted to any area of practice management that you can think of. The MGMA website is also a great place to look

for templates and articles related to performance reviews, employee coaching, budgeting, marketing your practice, etc.

RPA Connect has a similar kind of ongoing flow of information through member posted discussion topics and questions. The beauty of this resource is that it is all nephrology all the time. Everyone responding to questions understands our unique environments, and we have pros from every geographic area and size of practice weighing in with their wisdom.

AMA website. This is an especially important resource for guidance about the E&M changes that went into effect January 1, 2021. Additionally, this website has a Practice Management section that contains articles on many relevant topics. AMA membership is not required for viewing the complete articles.

The LDO's websites, blogs, and webinars are chock full of information and guidance on patient care topics and communication as well as those related to clinic safety.

Data wranglers such as Nephrologixx are able to help with benchmarking, assessments, and projections. This information can help you pinpoint the right time to bring on another provider or reveal troubling trends in office volume.

The CMS website contains information on everything from regulations and billing to local coverage determinations and fraud and abuse prevention.

Financial advisors have webinars and videos pertaining to budget planning, record retention laws, PPP loan forgiveness, and record keeping.

Conferences. Even though we will likely attend these events virtually for the foreseeable future, there is no shortage of information to be had. I attended my first National MGMA Conference in October and was so impressed by the format, speakers, and interesting topics. A conference can really recharge your batteries and give you a fresh perspective on what you deal with daily. The Annual RPA Meeting in March will provide an excellent opportunity to connect with our peers and learn through a robust Business Management Track created with you in mind.

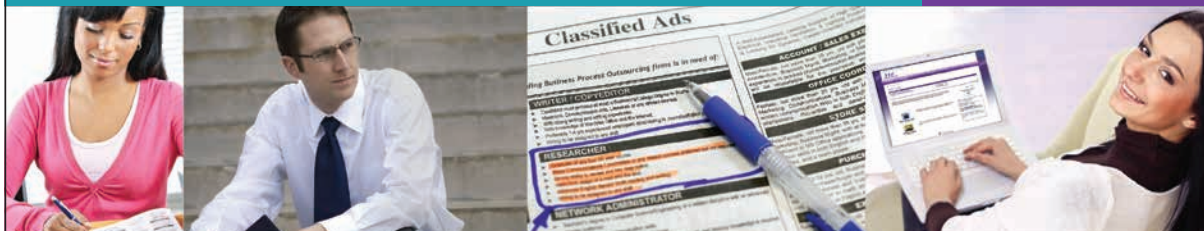
Combining all of these resources with our body of knowledge and our experience in the trenches should make us feel prepared to lead our practices into 2021. We are needed now more than ever.

Despite the panic, uncertainty, and fear of a pandemic, I saw real courage, commitment, and action in my practice and among our colleagues. People showed up to work every day to take care of our patients, even though they were nervous and fearful of bringing the virus home to their families. They came in with their game face and masks on and brought their senses of humor, Clorox wipes, and homemade hand sanitizer. If we were lucky enough to survive 2020 with our practices intact, we should stand back for a moment to reflect, look around, maybe exhale, give ourselves a quick pat on the shoulder and get back in there. Because as a practice manager, you know there is always more to be done. ■

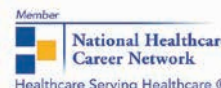
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RPA PAC Offers a Holiday Message of Thanks, and Hope

While you're reading this article sometime around the New Year, it is being drafted just after Thanksgiving, and these bookends of the holiday season offer perspectives on life that are differing in orientation but similar in their positive messages. RPA PAC thanks its members for your support during a challenging year (that's the understatement of the century, and that one might hold up until 2099). We thank those who supported the PAC in the spring, as well as those who responded to separate calls for RPA PAC support later in the year. RPA PAC also offers gratitude for those of you reading this who didn't get the opportunity to make a PAC donation in 2020, because by virtue of reading this newsletter you are a member (or are 'member adjacent') of RPA, and your participation in your specialty society is especially important these days and not taken for granted. [That said, jump on into the RPA PAC pool in 2021; the water's fine!]

The New Year presents numerous reasons for hope. Recent weeks have seen the emergence (at press time) of three vaccines that will ideally provide a significant degree of immunity from COVID-19. Further, as time goes on, the lessons learned by the medical community in the treatment of the virus will only increase. And at the risk of making a political commentary, the prospective Biden administration seems likely to make health policy decisions based on science and evidence, and that can only contribute to advancing the effort to end the pandemic. All of that is not to say the next few months won't be exceptionally difficult (because they will be), but only to point out that the light at the end of the tunnel may be emerging.

As for candidates that the PAC supported in the weeks leading up to Election Day, they were all on the House side and included Zoom meetings (that's how it's going these days, folks) with Reps. Larry Bucshon (R-IN, member of the Energy and Commerce Health Subcommittee and Co-Chair of the Congressional Kidney Caucus), Jaime Herrera Beutler (R-WA and longtime kidney care advocate who is the wife and mother of a kidney donor and recipient, respectively), Annie Kuster (D-NH, another member of the E&C Health S/C), Anna Eshoo (D-CA, Chair of the E&C Health S/C and one of the primary

movers in the House of the immunosuppressive drug coverage bill), and Cheri Bustos (D-IL). All five of these members of Congress were reelected, although things looked dicey for Ms. Bustos just prior to election day, but she prevailed by an unexpectedly narrow margin.

As for the Congressional election results more broadly, anyone paying attention knows that the Republicans had a surprisingly great day, holding control of the Senate for the moment and slicing nicely into the Democratic margin in the House, although even as this is written at Thanksgiving, the final tally is yet to be determined. The run-off elections in Georgia on January 5 will determine control of the Senate, and while it would be surprising if the Democratic challengers won either race and borderline shocking for them to win both, it seems that the GOP leadership isn't doing themselves any favors by sowing doubts about the validity of the electoral process among the conservative electorate, although it might be that in retrospect on January 6, that proved to be an overblown narrative.

Whatever the results in January end up being, please consider helping with RPA's ability to engage with Members of Congress by donating to the RPA PAC today at <https://www.renalmd.org/donations/fund.asp?id=15453> or send a personal check to RPA PAC, 1700 Rockville Pike, Suite 220, Rockville, MD 20852. If you have any questions, please contact RPA's Director of Public Policy Rob Blaser or the RPA PAC Treasurer Mary Orgler 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*.

PLATINUM (\$100,000)	GOLD (\$50,000)	SILVER (\$25,000)	BRONZE (\$10,000)
Amgen AstraZeneca Pharmaceuticals	Akebia Therapeutics Avenu Medical Bard Peripheral Vascular, Inc. DaVita Kidney Care Fresenius Medical Care Medtronic	AtCor Medical, Inc. Aurinia Pharmaceuticals Baxter Healthcare Janssen Pharmaceuticals Natera Novartis Otsuka Pharmaceuticals Relypsa, Inc. Rockwell Medical Tricida, Inc.	Bluegrass Vascular CHF Solutions Laminate Medical Technologies Medibeacon, Inc. OPKO Pharmaceuticals Sonavex, Inc.



E&M Code Changes; TCM

Q I have heard that there will be changes to the office visit codes for 2021. What do I need to know to file claims and maintain correct documentation and record keeping?

A There are many changes slated to be implemented regarding the office visit or outpatient E&M codes proposed for 2021. However, at press time the possibility exists that some of the changes may be rolled back due to advocacy efforts by some specialties seeking to address the proposed reduction in the 2021 fee schedule CF.

Highlights of changes scheduled for implementation include:

- CPT code 99201 has been eliminated;
- The need to document a recounted patient history and different physical examination elements has also been eliminated;
- Moving forward, the documentation only needs to be based on the complexity of medical decision making (MDM) or the total time associated with that specific patient encounter on the day of the encounter; and
- An MDM complexity add-on code, temporarily specified as GPC1X, has also been proposed to account for “complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed healthcare services and/or with medical care services that are part of ongoing care related to a patient’s single, serious, or complex chronic condition.” CMS has proposed work RVUs of 0.33 and 0.49 total RVUs for the service.

The times associated with the E&M codes have changed as well, now expressed as ranges with most time ranges increased (see chart below), but now it is not just the time spent by the physician face-to-face with the patient or family but as noted the total time for that encounter on the day of the encounter (not just the face-to-face time). In addition to usual face-to-face activities such as performing the exam and counseling and educating the patient, documenting clinical information in the electronic or other health record is now included as being a part of the encounter. Also, activities such as referring to or communicating with other healthcare professionals, interpreting results of tests and labs, and care coordination can be counted, as long as they are not separately reported. Time spent by non-billing team members, such as medical assistants, lab techs, and office staff, cannot be included in the total.

Changes to the CPT-Defined Times

Code	Time 2020 (minutes)	Time 2021 (minute ranges)
99201	10	eliminated
99202	22	15-29
99203	29	30-44
99204	45	45-59
99205	67	60-74
99211	5	N/A
99212	16	10-19
99213	23	20-29
99214	40	30-39
99215	55	40-54

The RVUs for all outpatient E&M codes increased for 2021, but because of the CF reduction, only five of the eight commonly used outpatient E&M codes are slated for actual payment increases (see chart below). That said, the RVUs for services commonly provided by nephrologists to persons with CKD (the established patient E&M codes 99212-99215) all are proposed to have substantial payment increases even with the CF reduction.

Work RVU (wRVU) and Approximate Value Changes 2020-2021
RVU Values

Code	2020 wRVU	2021 wRVU	2021 wRVU
99202	0.93	0.93	0
99203	0.97	1.6	0.63
99204	2.43	2.6	0.17
99205	3.17	3.5	0.33
99212	0.48	0.7	0.22
99213	0.97	1.37	0.4
99214	1.5	1.92	0.42
99215	2.11	2.8	0.69

Monetary Value

2020 Value	2021 Value	20-21 Value Change
\$ 33.56	\$ 30.00	\$ (3.56)
\$ 35.01	\$ 51.62	\$ 16.61
\$ 87.70	\$ 83.88	\$ (3.82)
\$ 114.41	\$ 112.91	\$ (1.50)
\$ 17.32	\$ 22.58	\$ 5.26
\$ 35.01	\$ 44.20	\$ 9.19
\$ 54.14	\$ 61.94	\$ 7.80
\$ 76.15	\$ 90.33	\$ 14.18

Conversion Factor (CF) 2020 CF = \$36.09 2021 CF = \$32.26

The elements determining MDM are the number and complexity of problems addressed at the encounter, the amount and/or complexity of the data to be reviewed and analyzed, and the risk of complications and/or morbidity and mortality associated with the patient management. As a general rule of thumb, CPT codes 99202 and 99212 can be considered to have straightforward MDM with a minimal number and complexity of problems, 99203 and 99213 have a low degree of MDM and a low number and complexity of problems, 99204 and 99214 are characterized by moderate MDM and number and complexity of problems, and 99205 and 99215 have a high degree of MDM and number and complexity of problems.

To the extent that some of the proposed changes affecting coding and documentation have not been finalized for January 1, 2021, at press time, RPA will report on updates through the weekly enews.

Q My Medicare carrier was rejecting my claims for transition of care services for dialysis patients until I used the physician’s office as the place of service instead of the dialysis facility, but now I’m hearing that a coding edit will prevent our practice from billing and receiving payments for these services for dialysis patients. Is the service billable, and if so, how?

A The short version of this answer is that the transitional care management (TCM) service is billable when provided to monthly dialysis patients, and while a National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) coding edit affecting the services did appear in the last quarter of 2020 (beginning on October 1, 2020), it is expected to be removed on January 1, 2021.

A longer version of the story is that for the calendar year 2020 Medicare Fee Schedule, CMS finalized a proposal to allow the services to be provided concurrently with ESRD monthly capitated payment (MCP) services; previously, concurrent billing with the MCP codes had been prohibited. CMS realized that utilization of the TCM codes was significantly lower than they expected and made a determination to remove the prohibition on concurrent billing with the ESRD MCP codes, among several other families of services.

While, according to Medicare, the service was now covered when provided to ESRD patients, they have not issued an instruction transmittal or guidance to carriers on how to pay the claims, and this has resulted in confusion, with some MACs paying for the services with place of service (POS) code 65 for the dialysis facility, and others only covering the service when provided in POS 11 for the physician’s office. CMS staff have verbally advised RPA staff that either POS is acceptable from their perspective, but that has not been clarified in written form to the MACs yet.

Adding to the confusion was the PTP edit created by NCCI effective October 1, which prohibited concurrent billing for the two services at the coding level (as opposed to the CMS coverage level). However, upon learning of the edit, RPA staff contacted NCCI staff and provided them with the language from the 2020 fee schedule final rule allowing concurrent billing for TCM and ESRD MCP services, and received a prompt response that CMS has reviewed the request and is making changes based on it. RPA will closely monitor the NCCI PTP edit and will keep RPA members advised accordingly. ■

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.

RPA ANNUAL MEETING VIRTUAL 2021

MARCH 18-20

E X P E R T I S E E X P E R I E N C E E X C E L L E N C E

**It's 2021 and we're doing
something different and better...**

Check out all the relevant topics we have lined up

Social Media

Get the 411 on leveraging the use of social media in healthcare: professional networking, education, patient care and more.



Advanced Practitioners

Learn how the role of Advanced Practitioners on the healthcare team improves patient outcomes in a collaborative model of care.



Business Management

Find out how having a business minded leader on your team can keep your practice serving the kidney community for years to come.



Industry Insights

This may be your one chance to chat with industry partners to get the latest updates and actions they are taking to improve kidney care during a pandemic.



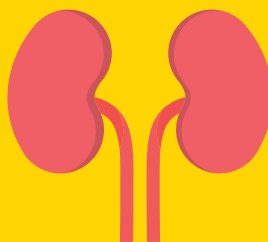
Disruptive Innovators

COVID-19 has radically changed healthcare, but technology is at our fingertips. Learn nontraditional ways and solutions on how innovation is disrupting the healthcare industry and breaking barriers.



Advanced Kidney Care Health

The AAKH Executive Order finally comes into force in 2021. Is your practice positioned for success? Learn the ins and outs of the KCC and ETC payment models from experts in the field and what steps your practice should be taking now to prepare.



Clinical Advances

This has been one of the most exciting years for kidney research in recent memory. If your head is spinning from all the new advances, our clinical experts will help break it down.



Early Career Physicians

We asked what you needed and we heard you loud and clear, that's why we have created opportunities during this meeting to build a strong foundation for your career.



This is just a snapshot to give you an overview of what to expect during **Virtual 2021**. Scan this QR Code to register and get access to the agenda to plan your personal experience.



Connect with us! #RPA21
Register today at www.renalmd.org