tions for our patients by incorporating alternative care, such as with cannabinoids. As cannabinoids become more actively incorporated into society as a key player in the wellness industry, perhaps a key demographic target will be older patients seeking alternative approaches in their medical decisions, particularly when it comes to significant lifestyle choices such as initiation of dialysis. Perhaps a palliative approach to CKD and ESRD management would be more palatable if it could, in fact, be made more palliative?

According to the United States Renal Data System, Medicare pays an annual $55 billion for the population of CKD patients aged 65 or older, and $65 billion on all patients with CKD (1). This is an enormous cost, without an enormous benefit to patients, who remain with the same burden of symptoms and treatment options that have been relatively stagnant for decades.

The economic benefit to alternative care in nephrology is an area that has yet to be explored, but recent data have shown that cannabis has led to a considerable influx of revenue for state governments, which can be on the order of billions (7). Developments in the advancement of legalization of cannabinoids and continued growth in the US market should consider the voice of our patients, who are likely to grow increasingly dependent on the product in their pursuit of an alternative approach to care. Likewise, we may need to advocate this option as an extension of our other therapeutic options. At the very least, this option may prove to be an effective, if not a cost-conducive alternative.

Our patients are getting older, have more comorbidities, and also have an overwhelming burden of symptoms. We know that too often, we have to tell them that they "can't get their kidneys back." We know that many of our patients are already engaging in forms of alternative care without telling us. We know that sometimes those forms of care may be harmful, and that there are other types of alternative care that we just do not know that much about. We also know that there are potential benefits in some more controversial therapies such as marijuana, and we know that the astronomical costs of care in nephrology could use some control.

Even if we are not sure about the ultimate role of alternative care to help ease our patients' symptoms, such care is already making headway in nephrology and may be here to stay. ■

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Policy Update

Evaluation and Management Codes Undergo Changes

In November 2018, Medicare released the final Physician Fee Schedule (PFS) rule containing revisions to evaluation and management (E&M) code documentation requirements. Earlier, in a press conference announcing proposed E&M changes in July, Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma said, "Evaluation and Management or E&M visits make up around 40% of all Medicare payments under the Physician Fee Schedule, and guidelines have not been updated since 1997—21 years ago," adding that nearly 750,000 clinicians use these codes. "The requirements often mean that doctors have to cut or paste chunks of information across medical records strictly for billing purposes."

In service of CMS' stated goal of reducing documentation burden in E&M coding, CMS proposed to collapse levels 2–5 of E&M coding into one reimbursement payment. This move had negative implications for nephrologists and other clinician groups practicing cognitive care with complex patients.

After receiving more than 15,000 comments on the proposed rule, CMS finalized the rule so that for CY 2019 and CY 2020, CMS will continue the current coding and payment structure for E&M office/outpatient visits with clinicians using either the 1995 or 1997 E&M documentation guidelines. Additionally, for CY 2019 and beyond, CMS is implementing the following policies:

- Elimination of the requirement to document the medical necessity of a home visit in lieu of an office visit;
- For established patient office/outpatient visits, when relevant information is already contained in the medical record, clinicians may choose to focus on reporting on what has changed since the last visit, or on pertinent items that have not changed, and need not re-record the defined list of required elements if there is evidence that the physician reviewed the previous information and updated it as needed;
- Additionally, CMS clarified that for E&M office/outpatient visits, for new and established patients, clinicians need not re-enter in the medical record information on the patient's chief complaint and history that has already been entered by staff or the patient. The physician may simply indicate in the medical record that she/he reviewed and verified this information; and
- Clinicians are no longer required to duplicate notations in medical records that may have previously been included in the medical records by residents or other members of the medical team for E&M visits furnished by teaching physicians.

Beginning in CY 2021, CMS will further modify the coding and reimbursement for E&M office/outpatient visits. CMS has finalized the following policies set to begin in CY 2021:

- CMS will pay a single rate for E&M office/outpatient visit levels 2–4 for established and new patients while maintaining the payment rate for E&M office/outpatient visit level 5;
- Permit physicians to choose to document E&M office/outpatient level 2–5 visits using medical decision-making (MDM) or time instead of applying the current 1995 or 1997 E&M documentation guidelines, or alternatively practitioners could continue using the current framework;
- Beginning in CY 2021, for E&M office/outpatient levels 2–5 visits, clinicians will have flexibility in how to document visit levels—specifically a choice to use the current framework, MDM, or time. For E&M office/outpatient level 2–4 visits, when using MDM or the current framework to document the visit, CMS will also apply a minimum supporting documentation standard associated with level 2 visits. For these cases, Medicare would require information to support a level 2 E&M office/outpatient visit code for history, exam, and/or medical decision-making;
- When time is used to document, clinicians will document the medical necessity of the visit and the required amount of time face-to-face with the patient;
- Implementation of add-on codes that describe the additional resources inherent in visits for primary care and particular kinds of non-procedural specialized medical care, though they would not be restricted by physician specialty. These codes would only be reportable with E&M office/outpatient level 2–4 visits, and their use generally would not impose new per-visit documentation requirements; and
- Adoption of a new "extended visit" add-on code for use only with E&M office/outpatient level 2–4 visits to account for the additional resources required when extra time is required.

After omitting nephrology from the list of specialties dealing with complex patients that could use an add-on code for complexity in the proposed rule, CMS wrote in the final rule that "We also agree with commenters that the code descriptor omitted several specialties that provide this type of visit, such as nephrology, psychiatry, pulmonology, infectious disease, and hospice and palliative care medicine…. As discussed previously, appropriate reporting of the specialty care resource add-on code should be apparent based on the nature of the clinical issues addressed at the E/M visit, and not limited by the practitioner's specialty."

The ASN Quality Committee will continue to analyze this rule further. ■