Big changes afoot with CMS Evaluation and Management Coding

By David L. White

Every summer, the Centers for Medicare & Medicaid Services (CMS) propose rules that govern physician reimbursement, the Medicare End-Stage Renal Disease (ESRD) program, and the newer Quality Payment Program (QPP), which is entering its third year in calendar year 2019. This summer has been no exception, with some proposed changes that benignly refine programs around the edges, and others that mark significant changes in course.

In July 2018, CMS released the ESRD PPS and QIP proposed rules. In what is expected to be a permanent change, the proposed rule for the first time combines the QPP and the Physician Fee Schedule (PFS).

The American Society of Nephrology (ASN) Quality Committee and ASN Council each year review and comment on these recommendations as they relate to nephrology and best practices in medicine. The committee and Council are currently reviewing the 2000 pages of proposed regulations, some of which are far-reaching in nature, in advance of the deadline for comment submission on September 10, 2018.

Following are highlights of the proposed changes.

Physician Fee Schedule/Quality Payment Program

Reducing Evaluation and Management (E&M) coding documentation

CMS Administrator Seema Verma discussed the E&M changes in a Health and Human Services (HHS) Department video.

"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," according to Verma, who added 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." Verma said this documentation process is a "poor use" of clinician time that detracts from direct patient care. "Time spent at the computer documenting and coding for visits is time doctors could be spending with their patients." In addition, she said that E&M codes "pack the medical records with information that isn't useful for patient care."

In the proposed rule, CMS states: "We propose to allow practitioners to choose, as an alternative to the current framework specified under the 1995 or 1997 guidelines, either medical decision making (MDM) or time as a basis to determine the appropriate level of E/M visit."

"If you add up the amount of time saved for clinicians across America, in one year from our proposal it would constitute more than 500 years of additional time available for patient care," Seema noted in the video.

However, CMS has coupled this paperwork reduction with a reimbursement policy that is sure to be far more controversial.

Creating a compressed single payment for E&M levels 2–5 (one for new patients and one for established patients)

CMS has proposed creating a single, flat payment for the compressed E&M levels 2–5 with one payment for new patients at a slightly higher rate due to CMS' expectations that a new patient will require more time on the clinician's part. The established patient's rate would be slightly less for the expected slight reduction in the time required with the clinician. This proposal has already drawn criticism from different parts of the medical community and was discussed in-depth at the ASN Quality Committee's in-person meeting in late July 2018.

Some are concerned that the new proposal will penalize clinicians who serve largely complex patients and who more commonly bill at levels 4 and 5. CMS is somewhat concerned about that effect and wants to create an adjuster to be used by some specialties; however, ASN Quality Committee members are concerned that the adjuster is not robust enough and CMS does not apply it to nephrology.

Allowing the scoring methodology for the End-Stage Renal Disease QIP to be used for clinicians who spend the majority of their time in the dialysis facility

This move is still being considered, and CMS has been signaling it for at least a year. CMS writes in the proposed rule on PFS/QPP: "We seek comment on the extent to which the quality measures of dialysis centers reflect clinician performance. Additionally, we seek comments on whether we might be able to attribute the performance of a specific facility to an individual clinician."

Creating new telehealth opportunities

Several provisions affecting telehealth are included in the proposed rule. One allows a clinician to bill for a non-face-to-face service that avoids an office visit and thereby benefits the patient and saves CMS money. CMS is seeking comment on what level of technical functionality clinicians believe is necessary for this service.

Second, CMS is proposing to pay clinicians for evaluating "store and forward" videos or images provided by a patient. As with the first provision, if the telehealth service leads to a patient visit, it would be bundled into that office visit reimbursement. The payment would occur when the service allows a patient to avoid coming in for an office visit.

ESRD PPS/QIP

Changing, expanding Transitional Drug Add-on Payment Adjustment (TDAPA)

CMS is proposing modifications to the designation process and expansion of TDAPA to all new drugs, not just those in new functional categories, for a period of two years.

The proposed rule revises the drug designation policy in TDAPA "to reflect that the process applies for all new renal dialysis drugs and biologicals that are approved regardless of the form or the route of administration, that is, new injectable, intravenous, oral, or other routes of administration or dosage form."

The proposed rule also removes four measures from the QIP: Healthcare Personnel Influenza Vaccination, Pain Assessment and Follow-Up, Anemia Management, and Serum Phosphorus, and adds transplant metrics.

These are just some of the more notable recommendations for these rules. ■

To read more about the QPP/PFS proposed rule, visit the ASN website at https://www.asn-online.org/policy/webdocs/QPP_PFS_Proposed_rule_2018-14985.pdf

To read more about the ESRD PPS QIP proposed rule, visit the ASN website at https://www.asn-online.org/policy/webdocs/2019_Proposed_Rule_Highlights.pdf

ASN Scores Wins in Appropriations Process

By Zachary Kribs, ASN Government Affairs Specialist

In July 2018, the House Appropriations Committee approved the annual Labor, Health and Human Services, and Education spending bill (LHHS), passing it to the House floor for consideration.

The bill, and its Senate counterpart, contain multiple priorities of the American Society of Nephrology (ASN), a direct result of the countless emails, meetings, and phone calls made by members to their legislators.

Chief among these priorities is a sizable increase for the National Institutes of Health (NIH). Working with peer organizations, ASN and its members were able to build on the momentum of previous years and advocate for a consistent, sustained increase for the NIH in Fiscal Year 2019—including in a letter signed by a record 37 patient, physician, and provider groups across the kidney and transplant community.

The Senate version of the LHHS bill proposes a $2 billion increase for the NIH, while the House version of the bill proposes a $1.25 billion increase. In addition to the topline NIH funding level, both bills also propose sizable increases for the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), $60 million in the Senate and $24 million in the House.

Another fixture of ASN's congressional advocacy has been the dissemination of a 2017 Government Accountability Office (GAO) report on the state of funding for kidney diseases research. The report found a significant discrepancy between the burden created by kidney diseases and investment in research of the diseases. At the time it was written the government spent more on treating kidney failure than on the entire NIH or NASA budget, while allocating less than 1% of that amount on kidney research.

The House bill includes language encouraging "NIDDK to continue working with stakeholders to disseminate critical information and discuss new opportunities for research," a clear acknowledgment of the report's findings and the work done by ASN and peer organizations to draw attention to the need for greater investment in kidney diseases research.

Immunosuppressive drug coverage; living donor provisions

The House bill also includes language encouraging CMS to address current policy surrounding the coverage of immunosuppressive medications after kidney transplantation. Currently, Medicare pays for costly immunosuppressive medications for only 3 years after receiving a transplant, leaving many recipients who cannot afford the medications at risk of transplant failure and in need of a new transplant.

In the proposed legislation, the House Appropriations Committee encouraged CMS to commission a study of

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