

Proposed E/M Coding Changes Overshadow Other Fee Schedule, Quality Provisions

By David White

On July 12, 2018, the Centers for Medicare & Medicaid Services (CMS) released a combined proposed rule for the Physician Fee Schedule (PFS) and the Quality Payment Program (QPP) for performance year 2019. Led by its Quality Committee, the American Society of Nephrology (ASN) has been reviewing the proposed changes, meeting with peer societies and coalitions, and drafting comments and recommendations. Most readers will have heard about one particular aspect of the proposed changes: recommendations by CMS to simplify Evaluation and Management (E/M) coding documentation requirements with the stated goal of providing relief from regulatory burden for clinicians. CMS has characterized this and other recommended changes as part of the Department of Health and Human Services' high priority *Patients Over Paperwork* program.

The proposed changes to E/M coding and valuation begin with a stated approach of allowing physicians to justify the level of complexity of a visit based on medical decision-making or time involved, but the result is a valuation system that many ASN members have characterized as devoid of nuance for the gradation of care involved.

The proposed changes are hugely impactful—even by CMS' own account. As CMS wrote in the proposed rule, "In total, E/M visits comprise approximately 40% of allowed charges for PFS services, and office/outpatient E/M visits comprise approximately 20% of allowed charges for PFS services." ASN and other stakeholders have long maintained that many of the E/M documentation guidelines are administratively burdensome and outdated with respect to the practice of medicine and recently provided CMS with examples of such outdated requirements, which sap clinicians' time and contribute to burnout. The good news is that CMS has listened to similar concerns from ASN and virtually every medical specialty society and proposes to ease those requirements.

The bad news is that CMS is proposing to make those positive changes as part of a larger, deeply concerning proposal to collapse payments for E/M codes 2–5 into a single payment. CMS would leave reimbursement for E/M level 1 visits as is.

In its comment letter, ASN will oppose the proposed com-

pression of reimbursement rates for E/M coding for levels 2–5 visits into a single reimbursement payment set. Specifically, CMS proposes to set the new, single payment around the current E/M level 3 payment. There will be one reimbursement rate for a new patient visit and one for an existing patient visit. This proposal reduces the reimbursement for the most complex patient encounters by \$76 per visit for new patients and by \$55 per visit for established patients, while reducing reimbursement for current level 4 visits by \$32 and \$16, respectively. ASN believes these proposed changes have many potential adverse consequences for patients and clinicians, particularly in nephrology. (Notably, the proposal does not affect the ESRD Monthly Capitated Payment.)

ASN has identified at least five areas of concern regarding the proposed E/M changes that would have negative implications for patients with kidney diseases:

1. Incentivizes non-patient centered care.
2. Reinforces the gap between cognitive and procedural care.
3. Disincentivizes CKD/preventive care.
4. Fails to account for critical patient care documentation needs.
5. Understates the impacts on nephrology practices, with reductions far higher than suggested by CMS.

Key to ASN's objections to the proposed changes is that in order to improve public health, nephrologists need to focus on efforts to slow the progression of kidney diseases, manage the complications of advanced kidney diseases, and optimally prepare patients for kidney failure, including preparations for dialysis, transplant, and conservative non-dialysis care. Kidney diseases affect more than 40 million people in the United States, with Medicare alone spending more than \$33 billion (1) annually on its End-Stage Renal Disease (ESRD) program and over \$103 billion (2) annually on all kidney diseases. This outlay does not include Medicaid, the Veterans Affairs Department, the Department of Defense, and private insurers.

Adjusting the E/M codes in the proposed manner has led to serious concern in the nephrology community. Many ASN members believe these efforts have historically been underval-

ued. The proposed PFS further disincentivizes clinicians from focusing on the complex, cognitive care that is required to slow the progression of CKD to dialysis and to optimally care for people who have received a kidney transplant.

Following are some of the other provisions of the proposed rule that were more welcome than the E/M payment reduction proposals:

- Paying physicians for their time when they reach out to beneficiaries via telephone or other telecommunications devices to decide whether an office visit or other service is needed.
- Paying for the time it takes physicians to review a video or image sent by a patient seeking care or diagnosis for an ailment.
- Eliminating the requirement to justify the medical necessity of a home visit in lieu of an office visit.
- Allowing practitioners to simply review and verify certain information in the medical record that is entered by ancillary staff or the beneficiary, rather than re-entering it.
- Starting in Year 3, permitting clinicians or groups to opt-in to MIPS if they meet or exceed one or two, but not all, of the low-volume threshold criteria.
- Liberalizing and expanding the rules for reporting methods and types in the QPP.
- Expanding MIPS-eligible clinicians to include physical therapists, occupational therapists, clinical social workers, and clinical psychologists.
- Weighting costs in MIPS at 15%, per congressional direction, instead of the original 30% weighting called for in the original MACRA legislation.

ASN will inform members of what CMS decides to include in the final rule due out this fall. ■

References

1. USRDS 2016.
2. Government Accountability Office, January 18, 2017. "Kidney Disease Research Funding and Priority Setting."

Advocates from Kidney and Transplant Community to Visit Lawmakers in September

By Zach Kribs

On Thursday, September 27, 2018, a broad coalition of advocates representing patients and physicians from across the kidney and transplant community will meet with their lawmakers in Washington, D.C., to raise awareness of critical issues facing the kidney community as part of ASN's fourth Kidney Community Advocacy Day (KCAD).

Recognizing the need to bring to lawmakers greater awareness of kidney diseases and the burden they place on over 40 million Americans, KCAD presents an opportunity for a community diverse in perspectives to speak in a unified voice. This year, participants will attend from 15 organizations representing patients, as well as kidney and transplant physicians, and will bring three key messages to their congressional delegations: increase investment in kidney research at the National Institutes of Health (NIH), support innovation in kidney medicine, including KidneyX, and co-sponsor the Living Donor Protection Act.

Advocates plan to build on the success of prior advocacy efforts to increase research funding and build support for

innovation in kidney medicine. Last year, extensive work by advocates participating in KCAD and across the entire medical research community helped result in a historic \$3 billion increase for NIH.

During KCAD, advocates plan to ask lawmakers for a \$2 billion increase for NIH—an amount recently supported by the Senate in its final spending package—and draw attention to the groundbreaking research conducted at the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) like the Kidney Precision Medicine Project, which aims to bring precision medicine to the kidney space.

Advocates will also call on Congress to support innovation in kidney medicine, including KidneyX, a public-private partnership led by the Department of Health and Human Services to seed, incent, and accelerate breakthroughs to promising new therapies for people with kidney diseases. Despite the significant burden of kidney diseases, there has been a dearth of innovation in the kidney space compared to other areas of medicine. During KCAD, advocates hope to create a sense of urgency among lawmakers about the need for innovation in

kidney medicine and show that the field is ripe for investment.

Finally, KCAD participants plan to keep pushing Congress to pass the Living Donor Protection Act. Designed to offer job security through the Family and Medical Leave Act and to prevent life, disability, and long-term care insurance plans from limiting or denying coverage to living donors, the legislation is a longstanding priority of the kidney and a transplant community. Advocates see passing the legislation as a key step in removing barriers to transplantation and to increasing access to a life-saving therapy.

Undergirding advocates' push during KCAD for congressional support of research and innovation is the uncertainty around the mid-term elections this fall. As races play out across the United States and Washington, D.C., prepares for a new Congress, maintaining the historic support for medical research and generating new enthusiasm among lawmakers—and new champions—is crucial. By participating in KCAD, advocates will demonstrate to Congress that the kidney community stands together in transforming care for the more than 40 million Americans living with kidney diseases. ■