Policy Update

Medicare Intermediaries Target More Frequent Dialysis; ASN Responds

By David White

Multiple deadlines are available in December to voice your opinion with the Medicare Administrative Contractors (MACs) regarding their announced plans to limit reimbursement for dialysis that occurs more than three times per week exclusively to patients who meet specific acute condition requirements.

Seven MACs covering eight jurisdictions (WPS, Novitas Jurisdiction H, Novitas Jurisdiction J, NGS Jurisdiction K, NGS Jurisdiction 6, Noridian Jurisdiction E, Noridian Jurisdiction F, and First Coast, Palmetto, CGS), covering over half of the country, released nearly identical draft Local Coverage Decisions implementing restrictive guidance related to more frequent dialysis.

Deadlines for sending in comments regarding proposed dialysis coverage requirements

Noridian Jurisdiction E & F – December 15, 2017
CGS Administrators Jurisdiction 15 – December 24, 2017

Within a very narrow timeframe, the MACs separately announced almost identical plans to limit reimbursement for more frequent dialysis exclusively to patients who meet specific acute conditions outlined in a draft Local Coverage Determination (LCD). These draft LCDs propose that any claim linked to a Plan of Care (POC) that includes dialysis treatments occurring more than three times per week—for any chronic condition or acute condition not included on the list—will be denied.

The American Society of Nephrology (ASN) has been working with a wide range of kidney groups and coalitions, including the Renal Physicians Association, Kidney Care Partners, the Alliance for Home Dialysis, and others to advocate for rejection of the LCDs. ASN asks members to reach out to their respective MACs to voice their concerns.

In comment letters to the MACs, ASN objects to the proposed policy change on the grounds that the change:

Violates the physician-patient relationship

ASN maintains that, as currently written, the draft LCD interferes with the patient-physician relationship in several ways. By proposing to establish a blanket denial policy for any claim linked to a POC that includes a dose of dialysis of more than three treatments per week, and by limiting the conditions that qualify as "medical justification" for more than three treatments per week to only a few acute conditions while excluding chronic conditions, the MACs inappropriately infringe upon the physician-patient relationship and establish substantial barriers to prescribing optimal treatments for individual patients.

Discourages medically justified individualized care

Clinical literature, as well as best practices and international guidelines, recognize that some patients with kidney failure may require more than three treatments per week on an ongoing basis in order to achieve and maintain optimal health, ASN said in comment letters. A peer-reviewed *American Journal of Kidney Diseases* Supplement on *Intensive Hemodialysis* published in November 2016 catalogs the literature supporting the prescription of additional hemodialysis sessions for the treatment of a number of different chronic conditions (1). Studies report that patients prescribed more than three treatments per week have been able to achieve improvements in, among other things, left ventricular hypertrophy, hypertension (using fewer medications), hyperphosphatemia, depression, posttreatment recovery time, sleep disturbances, and restless legs syndrome.

Does not recognize both acute and chronic conditions and care needs

ASN is concerned that if the LCD limits the conditions for more than three dialysis treatments per week to "acute" clinical conditions, this limitation would not be consistent with the clinical literature. As reflected in the names of conditions such as "chronic systolic [or diastolic] (congestive) heart failure," as well as others without the modifier "chronic," many conditions where more frequent hemodialysis is beneficial are chronic rather than acute in nature. Moreover, ASN asserts that it is contrary to best practices to treat patients when they have an acute episode, then stop the treatment approach that addressed the issue. Such a shortsighted strategy will, predictably, lead to another acute episode for many patients and risk re-hospitalization and resource use requirements that far exceed those of an additional weekly dialysis session.

Violates current CMS policy

ASN maintains that the proposed LCDs exceed the bounds of the MACs' authority in trying to restrict what conditions can be covered for more than thrice-weekly dialysis with medical justification. As CMS rules and guidance have made clear, the decision regarding medical justification must be made on an individual patient basis, making the proposed LCDs contrary to current CMS policy. CMS would have to rely upon notice-and-comment rulemaking, which is beyond the scope of the LCD authority.

- ***Case Study # 1***

Patient: A 30-year-old man with primary hyperoxaluria complicated by kidney failure.

Prescribed Treatment: To control his hyperoxalosis and prevent other end-organ damage, he required hemodialysis six times per week; he elected to perform this in-center.

Results: The patient was otherwise well, and he worked part-time as allowed by his dialysis schedule. He had no hospitalizations while receiving dialysis and ultimately received a successful liver-kidney transplant.

This is a good example of a patient with a chronic condition (hyperoxaluria) that is controlled by more frequent dialysis, with the POC calling for frequent dialysis. He was stable, and, therefore, more frequent care-planning would not have had value justifying its resource cost. He was seen most weeks by his physician, but not every week—and this was appropriate for his clinical state.

- ***Case Study #2***

Patient: An 80-year-old man treated with hemodialysis for more than 10 years with three hospitalizations in a six-week period due to fluid overload in the setting of heart failure with preserved ejection fraction. Despite aggressive education, he continued to gain substantial weight between sessions; this weight gain was in part due to chronic odynophagia, making fluids easier for him to swallow than solids. Each hospitalization came toward the end of the long interdialytic interval (Mondays, given that he was typically treated on a Tuesday/Thursday/Saturday schedule). His spKt/V at dialysis was ~1.8, consistent with adequate dialysis. He does not tolerate more than 2.5 to 3 kg of ultrafiltration per session, developing hypotension.

Prescribed Treatment: To control volume overload, he agreed to a fourth weekly dialysis treatment on Mondays.

Results: The fourth regularly scheduled session was documented in his POC. Following this prescription change, he had no further emergency department visits or hospitalizations for fluid overload. Given prior trends, if more than thrice-weekly dialysis was not provided routinely, he would be virtually certain to experience re-hospitalization; accordingly, integrating this into his POC (as opposed to writing weekly revisions to his dialysis prescription) was the most prudent course of action.

- ***Case Study Discussion***

ASN asserts that in these case studies, the provision of more than thrice-weekly dialysis was critical to the patient's health in the long-term (chronic need), not just in the short-term (acute need). Also, in both cases, the proposed new requirement that the patient's nephrologist file an acute order with medical justification for the additional dialysis session every week—as would be necessary under the proposed LCD—would make provision of optimal care more challenging for nephrologists, creating an administrative burden with no clinical utility. It would also create uncertainty and increased risks for the patient, and may increase tensions among physicians, patients, and dialysis facilities, with facilities objecting to medically indicated and prescribed additional treatments due to inappropriately strict criteria and resulting uncertainty of payment as delineated in the proposed LCD.

The ABCs of MACs

A. Medicare divides the country into 12 geographical jurisdictions.

B. It contracts with private companies to serve as MACs to process Medicare Part A and Part B medical claims.

C. MACs make Local Coverage Determinations (LCDs), but only Medicare can make national policy through the rulemaking process governed by the Administrative Procedures Act (2).

D. MACs pay $386 billion in Medicare benefits annually.

E. MACs process more than 1.2 billion Medicare FFS claims annually, 218 million Part A claims and more than 1 billion Part B claims (3).

References

1. http://www.ajkd.org/issue/S0272-6386(16)X0004-2
2. 5 U.S.C. & 500 et seq.
3. https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/What-is-a-MAC.html