



2010 Medicare Fee Schedule Final Rule Analysis

- **Nephrology Reimbursements Overall for 2010 to Increase 1%**
- **RVUs for Adult MCP Codes, Inpatient Dialysis Increased Slightly**
- **Cuts for Interventional Services Less than Originally Proposed**
- **Pricing for CKD Education Increased Significantly**
- **Consults Removed from Fee Schedule**

Executive Summary

The Final Rule for the 2010 Medicare Fee Schedule was released on October 30, and as usual the news is mixed for nephrology. The rule indicates that payments to nephrology as a specialty overall in 2010 will increase by 1% (less than the 2% increase indicated in the Proposed Rule). **The two highest volume services provided by nephrologists are still increased but these increases are down from what was indicated in the proposed rule. The relative value units (RVUs) for CPT code 90960 (the four visit monthly dialysis code for adults) are increased by 2.4% (down from 4.2% in July), and CPT code 90935 (inpatient hemodialysis, single evaluation) is increased by 1.6% (down from 3.8% in July). However, the significant cuts expected for the suite of interventional nephrology services have been substantially averted. The final rule also maintains increases for all of the outpatient pediatric dialysis codes.**

As was the case in the proposed rule, the changes in the impacts described above are mostly due to changes in the practice expense components of these codes, and as the practice expense RVUs for some services go down between the proposed rule and the final rule (i.e., the dialysis codes) they go up for other codes (i.e., the interventional nephrology services). Interestingly, as a result of the use of new data, the malpractice values for dialysis services have been slightly increased as well, although since the malpractice component of the fee schedule only comprises about 3-4% of the total RVUs, the impact of malpractice increases is limited at best. The net impact for the specialty as a whole is a 1% increase for 2010, and a 2% increase overall when proposed changes in the practice expense methodology are finalized in 2013. RVUs for commonly provided evaluation and management (E&M) codes are increased anywhere from 1-6%.

CMS continues to adhere to its perception of the legislative mandate with regard to the sustainable growth rate (SGR) and the conversion factor (CF), and thus the conversion factor for 2010 is reduced by approximately 21%, from \$36.06 to \$28.40; this is of course expected to be addressed legislatively by Congress prior to January 1st. On a positive note, the regulation finalizes the proposal to remove drugs from the calculation of the SGR formula, slicing approximately \$122 billion off of the ultimate cost of an SGR fix.

On other major issues of interest to nephrologists, CMS outlines the first model and payment structure for the chronic kidney disease (CKD) education benefit. With regard to payment, CMS was particularly responsive to renal community input, as it quadrupled the RVUs for the individual session code (from .53 work RVUs to 2.12 WRVUs) and doubled RVUs for the group session (from .25 to .50). RPA was among a host of kidney care provider groups advocating for such a change.

CMS did uphold its decision to eliminate the consultation codes from the fee schedule, over the objections of the vast majority of the organized medicine community, including RPA. Despite this decision, the actual financial impact on most specialties, including nephrology is expected to be negligible.

This analysis will discuss these and other issues of consequence to nephrology.

Detailed Analysis

Impact of Practice Expense Changes on Dialysis Services

As noted, virtually all dialysis services are increased slightly for 2010 from 2009 levels, and the vast majority of the gains are on the practice expense side (all of the work values are unchanged), with all of the increases in total RVUs being between 1-3%. The only dialysis code not increased is the adult daily home code (CPT code 90970), which is unchanged.

One revision CMS made in the final rule is that the implementation of the data gathered through the Physician Practice Information Survey (PPIS) will be transitioned over a four-year period ending in 2013, and thus there should continue to be slight increases in the practice expense values for the dialysis codes between now and 2013. For example, while CPT code 90960 is increased by 2.4% for 2010, by 2013 the scheduled cumulative increase for this service due to practice expense changes will be a projected 3.9%.

It is also worth noting that the Indirect Practice Expense Per Hour value (expressed as a dollar figure) for nephrology increased from \$49.60 to \$66.00. Further, any possible revisions emanating from the RPA survey of the inpatient dialysis codes and the subsequent AMA Relative Value Update Committee (RUC) review of these services (information which is currently embargoed) are not included in the 2010 RVUs.

Impact of Practice Expense Changes on Interventional Nephrology Services

While the provisions of the proposed rule seemed to indicate that draconian cuts for interventional nephrology services would occur in 2010, several methodological revisions implemented by CMS have substantially reduced the negative impact of the projected cuts. First, as noted above, CMS chose to use a four-year transition for implementing the changes flowing from use of the PPIS survey data, easing the one-year hits. Second, changes in CMS' assumptions governing equipment utilization benefitted vascular access

care. In the proposed rule CMS outlined a policy that would apply a 90% utilization threshold to expensive equipment priced at more than \$1 million (a 90% utilization rate translates into a machine being used 45 hours out of a 50 hour work week). The Agency appropriately has acknowledged that while the equipment utilized in vascular access suites cumulatively may be worth \$1 million, individually the pieces of equipment are not, and therefore the 90% rate should not apply. Further, CMS is applying the rate change only to diagnostic equipment (such as MRIs and CT scans) and not therapeutic equipment (such as those utilized in a freestanding vascular access center).

In summary, the codes for services commonly provided by interventional nephrologists will not take the huge hits previously expected. There will be a scheduled reduction of 6% due to the Deficit Reduction Act that was expected, and there will also be reductions to a number of codes in the 70000 series (generally, the codes in the 30000 series are stable). As a result, the reductions will be more along the lines of a 6-9% cut rather than the 22% reduction that was expected. RPA as part of a coalition of vascular access provider groups met with CMS in early September to express concern about the potential impact of these cuts on vascular access care, and the Agency appears to have responded appropriately.

Kidney Disease Education

The most significant news regarding CMS' handling of the soon to be covered kidney disease education (KDE) services is that the Agency acknowledged the substantial undervaluation of the services due to the crosswalk from the medical nutritional therapy codes. As a result, the values for the individual KDE sessions were quadrupled, and the values for the group sessions were doubled, as noted above.

Otherwise, on the KDE benefit CMS adhered to both its legislative mandate and what was outlined in the proposed rule. The services must be face-to-face, and will not be available via telehealth technology (the Agency does indicate that this could be addressed via future rulemaking in the 2011 fee schedule rulemaking cycle). CMS also specifies that "a session is one (1) hour long and may be provided individually or in group settings of 2 to 20 individuals who need not all be Medicare beneficiaries."

Eligible providers of care continue to be limited to physicians, nurse practitioners, physician assistants, clinical nurse specialists, and 'other providers' (defined as hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies or hospices). Renal dialysis facilities continue to be excluded from the list of eligible providers, and referrals for the KDE services can only be made by physicians. CMS also cited the legislative mandate in limiting the eligible beneficiaries for the services to those with stage four kidney disease (RPA and other groups in the kidney community called for the services to be available to those with *at least* stage four kidney disease, to capture those stage five patients who are not yet on dialysis).

CMS indicates in the rule that many commenters sought clarification on outcomes assessments and how they should be administered, whether they should be standardized, and whether pre- and post-assessment and comparisons should be performed. The Agency stated that it was encouraged by the interest in addressing outcomes assessment noting that “after reviewing the feedback received during the stakeholders meetings and from commenters, there does not appear to be a standardized or agreed upon outcomes assessment mechanism. While we are not making any changes in this final rule from the proposed outcomes assessment provisions, we are considering working with organizations that are developing outcomes assessments as they work to develop a standardized assessment tool.”

Regarding care delivery and payment issues, CMS received a large number of comments calling for the services to be able to be delivered ‘incident-to’, and in short dismissed them all, noting that such a change was out of their purview. On the payment level for KDE services, CMS includes the following language:

As a result of the comments we received and our own further analysis, we have adjusted the payment rates for G0420 and G0421 to reflect the 1-hour time limit for a session. We have multiplied the work RVUs for G0420 by four and the work RVUs for G0421 by two to account for the fact that we are crosswalking a 15 minute code to a 60 minute code (CPT code 97802 to G0420) and a 30 minute code to a 60 minute code (CPT code 97804 to G0421). We also adjusted the inputs for supplies.

As a result, if the conversion factor were to remain stable at \$36.06 for 2010, the national median reimbursement for an individual KDE session would be approximately \$108.18, and the national median reimbursement for the group session would be approximately \$25.60 (up from the approximately \$23.43 for individual education sessions and \$10.45 for group sessions noted in the proposed rule). RPA was among the groups calling for CMS to appropriately value the services to ensure that they would be provided, made a suitable adjustment to the values.

Removal of Consultations from the Fee Schedule

As noted, CMS upheld its decision to remove consultation services from the fee schedule. The Agency indicates it received a plethora of comments calling for it to delay the removal of the codes to allow for further study and development of alternatives, and to seek a process to account for the additional complexity inherent in the delivery of consultative care. In essence, CMS dismissed all of these concerns, in the following language:

Specifically, beginning January 1, 2010, we will eliminate the use of all consultation codes (inpatient and office/outpatient codes for various places of service except for telehealth consultation G-codes) on a budget neutral basis by increasing the work RVUs for new and established office visits, increasing the

work RVUs for initial hospital and initial nursing facility visits, and incorporating the increased use of these visits into our PE and malpractice RVU calculations.

Outside the context of telehealth services, physicians will bill an initial hospital care or initial nursing facility care code for their first visit during a patient's admission to the hospital or nursing facility in lieu of the consultation codes these physicians may have previously reported. The initial visit in a skilled nursing facility and nursing facility must be furnished by a physician except as otherwise permitted. Because of an existing CPT coding rule and current Medicare payment policy regarding the admitting physician, we will create a modifier to identify the admitting physician of record for hospital inpatient and nursing facility admissions. For operational purposes, this modifier will distinguish the admitting physician of record who oversees the patient's care from other physicians who may be furnishing specialty care. The admitting physician of record will be required to append the specific modifier to the initial hospital care or initial nursing facility care code which will identify him or her as the admitting physician of record who is overseeing the patient's care. Subsequent care visits by all physicians and qualified NPPs will be reported as subsequent hospital care codes and subsequent nursing facility care codes.

As proposed, this change will be implemented in a budget neutral manner, meaning that it will not increase or decrease aggregate PFS expenditures. We will make this change budget neutral for the work RVUs by increasing the work RVUs for new and established office visits by approximately 6 percent to reflect the elimination of the office consultation codes and the work RVUs for initial hospital and facility visits by approximately 0.3 percent to reflect the elimination of the facility consultation codes.

The end result of these changes on an RVU basis is that the new values assigned to the level three initial inpatient visit (CPT code 99223, which presumably would be provided to a complex kidney patient) are 11% higher than the previous level four inpatient consult code (99254) and are 7% lower than the previous level five inpatient consult code (99255). For the outpatient codes, RVUs assigned to the level five new outpatient visit code (99205) are 2.7% higher than the previous level four outpatient consult code (99244), but 19% lower than the previous level five outpatient consult code (99245).

Other Issues

Also included in the final rule are CMS' revisions for the 2010 **Physician Quality Reporting Initiative (PQRI)**, but for CKD and ESRD measures affecting nephrology there do not appear to be any substantive changes noted, as in the proposed rule. More measures and measure groups are being added to the PQRI initiative, but they are unrelated to nephrology. Similarly, on **e-prescribing** the status quo remains intact for nephrology as well. The list of non-office based services eligible for e-prescribing has increased, but despite RPA's comments calling for CMS to include the MCP codes among the denominator codes, they are still excluded.

Other provisions in the rule include refinement of the methodology for determining the **composite rate payment** for dialysis facilities, and are unchanged from the proposed rule. The regulation implements the MIPPA-mandated 1.0% increase in the composite rate, and also indicates that there is now parity between the payment rates for hospital based facilities and independent renal dialysis facilities.

The complete regulation (all 1669 pages of it) can be viewed at:

http://www.federalregister.gov/OFRUpload/OFRData/2009-26502_PI.pdf

Comments are due by close of business December 29, 2009.