



April 28, 2004

Stephen M. Phillips, Director
Division of Practitioner Services
Center for Medicare Management
Centers for Medicare and Medicaid Services
Room C4-01-27
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Mr. Phillips:

The Renal Physicians Association (RPA) is the professional organization of nephrologists whose goals are to ensure optimal care under the highest standards of medical practice for patients with renal disease and related disorders. RPA acts as the national representative for physicians engaged in the study and management of patients with renal disease. We are writing to outline those issues that we believe remain outstanding from the implementation of the revised dialysis reimbursement methodology for physicians, and to offer recommendations for the resolution of these issues. These points have been raised with CMS staff but would benefit from specific official clarification on the part of the Agency. RPA continues to have other major objections to the current G-code reimbursement structure, including but not limited to the unresolved geographic disparity issue and the inappropriate reimbursement equivalence for the second and third visit per month. These issues will not be addressed further in this letter; rather, we will focus on other areas requiring clarification or modification to ensure fair and appropriate implementation of the new structure.

Medical Necessity

It has come to our attention that the medical necessity of providing a fourth visit to an End Stage Renal Disease (ESRD) patient on monthly dialysis, particularly if the patient is in relatively stable condition, has been called into question by some Medicare carrier medical directors (CMDs). As a result, concerns have arisen that nephrologists who are in good faith working to achieve the aims of CMS by increasing the level of involvement they have with their patients may subsequently have the appropriateness and necessity of this level of involvement questioned by their carrier. RPA would contend that even though some patients in these situations are stable relative to their sub-population cohort, it is unreasonable at best and absurd at worst for CMS to implement a policy that strongly encourages four visits within a month's time to a dialysis patient, and then have the medical necessity of those visits challenged by a Medicare contractor.

RPA would therefore urge CMS to clarify the issue of medical necessity for visits provided to ESRD patients by instructing contractors administering Part B programs that, for the purpose of determining the medical necessity/appropriateness of the visits provided as part of the new G-Code reimbursement mechanism for the monthly capitated bundle of ESRD services, the patient's ESRD

status as certified by the completion of the 2728 form should serve as the medical necessity criteria for this specific series of CPT services.

Use of E&M Codes to Bill for Services Previously Billed Under the MCP

Two issues that have arisen since the implementation of the G-code reimbursement methodology are: (1) that unlike the previous MCP methodology, services rendered when the patient is in an observation status are not considered to be part of the G-code bundle, and thus visits provided in this setting cannot be counted toward the patient's monthly visit total; and (2) for those 'incomplete month' situations where the patient expires, undergoes a kidney transplant, or otherwise transfers out of the nephrologist's care prior to the provision of the monthly comprehensive visit, under the new system the nephrologist cannot be reimbursed for services provided in good faith prior to the disqualifying event.

CMS staff have advised RPA staff that the nephrologist should use evaluation and management (E&M) codes to bill for these services, but this solution does not account for edits existing in Medicare contractor software that will reject all E&M services provided to ESRD patients for renal-related services as covered under the capitated bundle of services. In the first situation, RPA would contend that the previous MCP codes and the new G-codes provide reimbursement for a bundle of services rendered to ESRD patients in outpatient settings, and the observation setting is an outpatient setting. Under the previous MCP system, nephrology accepted the fact that E&M services provided in the observation setting were part of the MCP outpatient bundle and thus were not separately billable—if services provided in this setting were billed, the claims would have been rejected due to the edits relating to renal services provided to ESRD patients. RPA would urge CMS to maintain consistency in defining which settings are considered to be outpatient, and either compel contractors to remove the edits causing claims denials or allow visits provided in the observation setting to count toward the patient's monthly visit total. With regard to incomplete month billing scenarios, it is RPA's belief that aside from likely problems caused by contractor coding edits, reimbursement for monthly management services for outpatient ESRD patients should reside within the ESRD payment structure. This could be accomplished by either allowing nephrologists to bill the one-visit G-code (G0319) for incomplete month patients regardless of how many interactions in excess of one occurred between the patient and the nephrologist, or by allowing the nephrologist to bill the appropriate frequency of whatever code representing less than a full month's service is finalized for providing care to transient patients.

Thus, the RPA recommendations to resolve the problems raised by the use of E&M service codes in traditional MCP situations are for CMS to **(1) remove the renal-related service claims edits for E&M visits provided to ESRD patients, or allow visits provided in the observation status setting to count toward the patient's monthly visit totals; and (2) for incomplete month situations, allow either the use of the one-visit G-code (G0319) or whatever code representing less than a full month's service is finalized for providing care to transient patients.** These resolutions would provide clarity to both Medicare contractors and nephrology practices and be more consistent with the previous MCP policy under the revised G-code methodology.

Transient Patient Billing

There continues to be substantial confusion among the Medicare Part B carriers and nephrology practices over the proposed methodology for providing services to and receiving reimbursement for transient patients. The December 'Questions and Answers' document disseminated by CMS indicates that providers should use CPT code 90935, hemodialysis, single evaluation, for these services. This is similar to the recently revised application of that code for services rendered to patients expected to regain their kidney function (acute renal failure patients), which represented the first usage of 90935 on an outpatient basis. However, a significant number of nephrology practices have contacted RPA to advise that none of their 2004 claims for transient patients submitted using 90935 have been paid, and some carriers have

advised nephrologists that claims for transient patients using 90935 will not be reimbursed, with no alternative offered. The revised methodology utilizing G-codes has been in effect since January and many providers, particularly in resort or 'snowbird' areas, have substantial numbers of claims still in a pending status, with no methodology for seeking reimbursement for services already rendered to the patient available.

RPA would therefore strongly urge that CMS develop and implement a separate G-code for transient patients as soon as possible. As noted in the previous section, use of such a code could resolve both the transient patient billing and the incomplete month billing issues, and could be based on the per-day codes used previously under the MCP system and currently for home dialysis (G-code G0327 for adult patients).

Use of CPT Nomenclature

In several of the communications disseminated by CMS on the revised dialysis payment methodology, including the Medicare Fee Schedule Final Rule published in the November 7, 2003 *Federal Register* and the December 'Questions and Answers' document, language is used in reference to the visits to be performed under the new methodology that have a specific, carefully defined meaning when used in the context of CPT coding issues. For example, in the final rule when discussing documentation requirements, the phrase "physical examination" is used, and the 'Questions and Answers' document makes use of the phrase "comprehensive monthly examination." **RPA strongly recommends that the words 'comprehensive' and 'examination' be removed from future CMS guidance in order to reduce any confusion with the CPT definitions of those words. We believe that alternate descriptors such as 'dialysis assessment' and 'dialysis encounter' would be much more reflective of the level and type of activity that would occur during both the complete assessment of the patient's condition performed monthly, as well as the more cursory encounters occurring in addition to the complete assessment, and RPA thus urges CMS to utilize these terms in future communications.**

Please feel free to contact Robert Blaser, RPA's Director of Public Policy, at 301-468-3510, if you have any questions or concerns regarding this correspondence.

Sincerely,



James Weiss, M.D.
RPA President

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