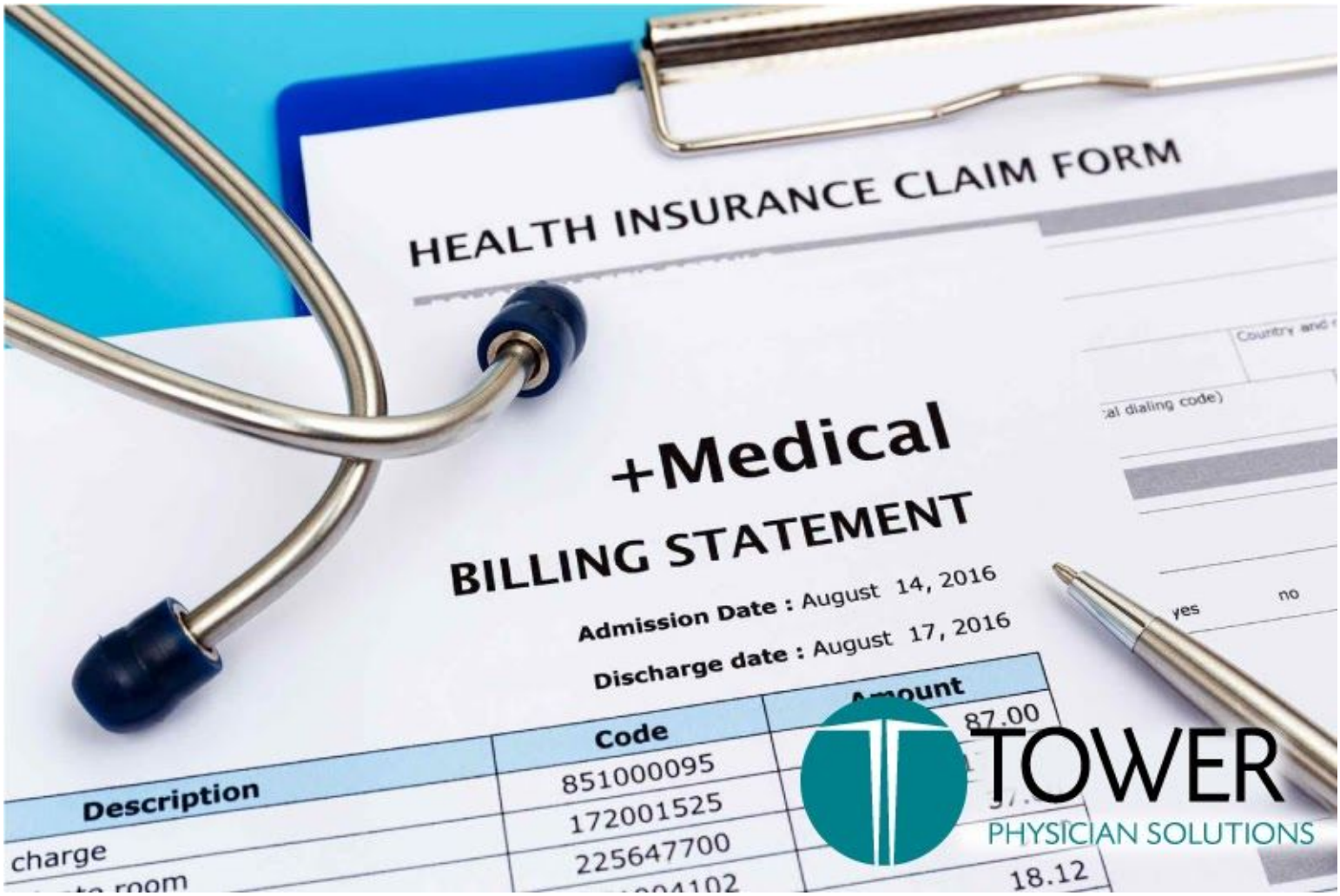
How CMS will change physician payment in 2020



As reported by CMS, Nephrology-Specific Payment Issues

On payment issues specific to nephrology, the specialty is slated for a 0% impact for 2020. All dialysis codes, inpatient and outpatient, adult, pediatric and daily, experience increases of between 0.1% and 1.0%, except for CPT code 90970, the adult daily dialysis code, which was increased 4.5%. CPT code 90960, the adult in-center, four-visit code, increases 0.8%, which, with the increase in the conversion factor (discussed below), works out to a $2.21 increase (unadjusted for geography). Meanwhile, CPT code 90935 (hemodialysis, single evaluation) is increased by 0.4%, working out to a $0.32 bump. Regarding the dialysis circuit codes for interventional dialysis services, the two high volume codes, 36902 (angioplasty) and 36905 (thrombectomy with angioplasty) experience 2.5% and 3.0% increases when these services are provided in the physician office setting.

One bit of very positive news is that CMS also made final its decision to allow billing of the transitional care management (TCM) codes (CPT codes 99495 and 99496) in conjunction with the adult outpatient dialysis codes (CPT codes 90960, 90961, 90962, 90966, and 90970).Previously, billing the TCM codes on ESRD patients had been prohibited. What this means for a nephrology practice is that if you follow a patient after discharge and comply with the documentation and other requirements of the TCM codes, you can bill Medicare and be reimbursed

approximately $187.67 for CPT code 99495 (this is the 14-day post-discharge code) and $247.93 for CPT code 99496 (the 7-day post-discharge code).

The final rule also confirmed CMS' proposal to create separate coding and payment for Principal Care Management (PCM) services, but with some changes. CMS states in the rule that qualifying conditions for these services "would typically be expected to last between three months and a year, or until the death of the patient, may have led to a recent hospitalization, and/or place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline." Additionally, CMS noted in the rule that the PCM codes would not be billable by the same practitioner for the same patient concurrent with certain other care management services and includes the monthly capitated ESRD codes among these excluded services, with which we agree. RPA comments on the proposed rule noted that "the PCM codes could prove to be useful in the care of CKD patients not yet on dialysis, and thus [we] believe the proposed PCM codes would provide another avenue toward optimizing care for those patients."

As for the changes in the PCM services, different codes were assigned to the services, with G2064 being the code for 30 minutes monthly of PCM services provided by a physician, and G2065 for 30 minutes monthly of PCM services performed by clinical staff directed by a physician. Additionally, the RVUs were increased for both services in the final rule over what was outlined in the proposed rule, with the total non-facility (outpatient) RVU for G2064 being 2.55 (for an allowed reimbursement amount of $92.03, unadjusted for geography), and the same RVU for G2065 being 1.10, resulting in an allowed reimbursement of $39.69, unadjusted for geography.

CMS finalized the removal of all nephrology-specific measures from MIPS.

- MIPS 328 Pediatric Kidney Disease: ESRD Patients Receiving Dialysis: Hemoglobin Level < 10 g/dL
- MIPS 329 Adult Kidney Disease: Catheter Use at Initiation of Hemodialysis 3
- MIPS 330 Adult Kidney Disease: Catheter Use for Greater Than or Equal to 90 Day
- MIPS 403: Adult Kidney Disease: Referral to Hospice

Increasing Data Threshold for Quality Measures

CMS finalized their plan to adopt a higher data completeness threshold for the 2020 MIPS performance period, such that MIPS eligible clinicians and groups submitting quality measure data on QCDR measures, MIPS CQMs, or eCQMs must submit data on at least 70 percent of the MIPS eligible clinician or group's patients that meet the measure's denominator criteria, regardless of payer for the 2022 MIPS payment year.