Implications of 2018 Medicare Fee Schedule Final Rule for Nephrology

- RPA Recommendations on Interventional Dialysis Circuit Code Values Implemented
- Nephrology Reimbursement Remains Stable
- Conversion Factor Increased Approximately $0.11, Set at $35.99
- Home Dialysis Code Family Still Noted as Misvalued, But Without Specific Direction for Revaluation
- Value for Apheresis Services Increased

On November 2 CMS released the final rule for the 2018 Medicare Physician Fee Schedule, and largely the news is good. Most significantly, CMS acted on RPA’s comment that the 2017 RUC recommendations for the dialysis circuit code family be implemented, resulting in increases in value for every code in the family. Additionally, CMS once again provided no specific instruction for the revaluation of the purportedly misvalued home dialysis codes, allowing for the possibility that these codes may not require the need for a survey in the coming months.

Regarding the features of the fee schedule RPA tracks each year, nephrology has a 0% specialty-specific impact for 2018, once again putting the specialty right in the middle of all specialties. The relative value units (RVUs) for all of the outpatient adult dialysis codes either hold steady or go up by a hundredth of an RVU point or two (some pediatric codes are reduced by a similar degree). The conversion factor is increased by $0.11, from $35.88 to $35.99; the combined impact of this on the adult in-center MCP, for example, will be an approximate $1.23 increase for 2018.

Nephrology and General Physician Payment Issues

As in recent years, the overall impact of the final rule on nephrology reimbursement is projected to be 0%. This plays out in the code level relative value unit (RVU) impacts, which for all dialysis codes, inpatient and outpatient, pediatric and adult, home and daily, are unchanged or have RVU increases or decreases of 0.10% or less compared to the 2017 RVUs. Most of the dialysis codes experience very slight increases, so the payment impact of these changes is minimal.

There is good news with regard to the 2018 conversion factor (CF) as it is valued slightly higher in the final rule than what was proposed in July ($35.9996 vs. $35.9903). [The conversion factor is the multiplier expressed as a dollar figure through which Medicare
increases or decreases overall reimbursement to Medicare Part B providers. The 2018 conversion factor as set in the final rule is more than an $00.11 increase over the 2017 CF of $35.8887. In recent final rules the CF was reduced from what had been in the proposed rule, so this again is a positive development.

**2017 RUC Recommendations for Dialysis Circuit Codes for Interventional Services Implemented; All Codes in Family Increased**

A clear victory was won when CMS reversed a decision it made for the 2017 fee schedule and implemented previous RUC recommendations for these codes, restoring some value for the service code family. Recall that the dialysis circuit codes represented a fundamental restructuring of vascular access care for 2017, and on top of RUC recommendations for the services that reduced the value of the services, CMS further reduced the values for these services beyond what the RUC recommended.

An RPA-led advocacy effort called on CMS to restore the values for these services to the RUC recommended levels based on our belief that the ‘typical patient’ used to develop the values for the 2017 fee schedule did not represent the complexity of the care associated with these services. This argument convinced CMS, as they noted in the final rule that:

> After further reflection, we are persuaded by commenters’ explanations regarding the complexities of care related to this patient population specifically and after reviewing these additional remarks, agree that these services are currently misvalued. Therefore, for CY 2018, we are finalizing the CY 2017 RUC-recommended work RVUs for CPT codes 36901-36909, consistent with the requests of public commenters.

The payment increases apply to every code in the code family, and with accounting for the approximate $00.11 increase in the conversion factor, range from a 1.1% increase in payment for CPT code 36903 (intro of catheter, angiogram with angioplasty and stent), to a 5.27% increase for CPT code 36901(intro of catheter, angiogram only).

**Home Dialysis Service Codes’ Designation as Misvalued Upheld, but Values Slightly Increased for 2018**

CMS reaffirmed its identification of CPT codes 90963-90970 as misvalued, but made no other reference to the issue in the entire proposed rule, saying only that “in the CY 2017 PFS final rule, we finalized for review a list of potentially misvalued services, which included eight codes in the end-stage renal disease home dialysis family (CPT codes 90963-90970).” As noted in the RPA summary of the proposed rule, language of this nature would normally mean that the codes would be going through the revaluation process, but the final rule never addresses this, and even includes the slightest of increases in value for all of the monthly home dialysis codes (for example, CPT code 90966, adult home dialysis, is increased from 6.70 to 6.72). Given recent regulatory changes requiring any RVU modifications to be included in both the proposed and final
fee schedule rules for a given year, and the time involved in making such changes, it
seems all but certain that any changes in value that might occur affecting the home
dialysis codes will not happen before 2020.

**Increase in Value for Apheresis Services**

**CMS finalized proposed increases for all of the codes in the revised apheresis code family** (recalling that CPT code 36515 has been deactivated and these services should now be billed using CPT code 36516). In the proposed rule CMS expressed some skepticism regarding the RUC recommendations despite including those values, raising concern regarding the direction the Agency might take with these services. However, in the end CMS did finalize all of the RUC recommendations for these services, resulting in increases of 15% and higher for a majority of the codes.

**Medicare Diabetes Prevention Program Expanded Model**

The final rule also implements the Medicare Diabetes Prevention Program (MDPP) expanded model starting in 2018. The MDPP expanded model was announced in early 2016, when it was determined that the Diabetes Prevention Program (DPP) model test through the Center for Medicare and Medicaid Innovation’s Health Care Innovation Awards met the statutory criteria for expansion. The final rule includes additional policies necessary for suppliers to begin furnishing MDPP services nationally in 2018, including the MDPP payment structure, as well as additional supplier enrollment requirements and supplier compliance standards aimed to enhance program integrity.

**Evaluation and Management (E/M) Guidelines**

CMS continued its discussion of a multi-year effort to revise the Evaluation and Management Guidelines to accompany a desire to reduce administrative burden to physicians, but only states that “we will consider the best approaches for such collaboration, and will take public comments into account as we consider the issues for future rulemaking.” The Agency had suggested in the proposed rule a focus on eliminating guidelines related to history and physical examination, with greater importance placed on medical decision making and time spent performing the service.

**Telehealth and Remote Monitoring**

In the final rule, CMS finalized separate payment describing certain forms of remote monitoring using CPT code 99091 (Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, for 2018 pending anticipated changes in CPT coding. The Agency also finalized a proposal to eliminate the required reporting of the telehealth modifier GT for professional claims in an effort to reduce administrative burden for practitioners.
Quality Reporting

**PQRS and Meaningful Use Quality Reporting**

Previously in CY 2016 physicians were required to report 9 measures across 3 National Quality Strategy Domains, with one cross-cutting measure included. In this final rule, CMS finalized its plan to only require physicians to report 6 measures for 50 percent of applicable patients with no domain or cross-cutting measure requirements. This aligns the PQRS CY2016 and Meaningful Use quality reporting requirements with the new quality reporting requirements for physicians under MIPS. However, web-interface and measure group reporting criteria remain the same and no new PQRS data will be collected.

In addition, CMS previously finalized in CY 2016 that groups of 100 or more eligible clinicians who participated in 2016 PQRS under the group reporting option (GPRO) were required to administer the CAHPS for PQRS survey. To align with the MIPS requirements, CMS made the CAHPS for PQRS survey optional under GPRO for practices of 100 or more eligible clinicians in 2016.

**Value-Based Modifier (VM)**

CMS finalized the following changes:

- Hold all groups and solo practitioners who met 2016 PQRS reporting requirements harmless from any negative VM payment adjustments in 2018. This proposal would apply to groups and solo practitioners who would have otherwise received downward adjustments based on their quality composite score, their cost composite score, or both;
- Halve penalties for those who did not meet PQRS requirements to -2 percent adjustment factor for groups with 10 or more eligible professionals, and to -1 percent for smaller groups and solo practitioners;
- Reduce the maximum upward payment adjustment to 2 times an adjustment factor (+2.0x) that is set at the rate needed to keep penalties and bonuses budget neutral.
- Drop its earlier proposal to publicly report 2016 value modifier data on its Physician Compare web site.

**Final Rule Link**

For the text of the final rule, see: