



American Society of Pediatric Nephrology

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September 27, 2019

Seema Verma
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1715-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

SUBMITTED ELECTRONICALLY VIA <http://www.regulations.gov>

Re: Medicare Program; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations (CMS-1715-P)

Dear Administrator Verma:

On behalf of the American Society of Pediatric Nephrology (ASPN), thank you for the opportunity to comment on the CY 2020 Physician Fee Schedule (PFS) proposed rule.

Founded in 1969, ASPN is a professional society composed of pediatric nephrologists whose goal is to promote optimal care for children with kidney disease and to disseminate advances in the clinical practice and basic science of pediatric nephrology. ASPN currently has over 700 members, making it the primary representative of the Pediatric Nephrology community in North America.

Children with kidney disease are medically vulnerable and complex patients. Those with end stage renal disease (ESRD) are at risk for significant medical morbidity such as growth failure, neurocognitive impairment, anemia, and frequent hospitalizations as well as a significantly higher mortality than the general pediatric population. Besides these special medical needs, this segment of the pediatric population is unique in that they are eligible for Medicare based on their ESRD diagnosis. Approximately one-third of our pediatric patients with ESRD have Medicare coverage. As such, our members are impacted by the policies proposed in this rule and offer the following comments.

Evaluation and Management Visits

In last year's final PFS, CMS included the first significant changes to the documentation of evaluation and management (E/M,) services, scheduled to take effect on January 1, 2021. Under this policy, physicians would no longer be required to document these services according to the 1995/1997 guidelines and instead would have the choice to document according to the level 2 requirements for medical decision making, the 1995/1997 guidelines for any level 2 through 4 service, or by time spent delivering care. Concomitantly, CMS also condensed the level 2 through 4 visits to a blended single payment level.

ASPN strongly supports CMS's goal to reduce the administrative burden associated with the documentation of E/M services and commends CMS for reassessing and adopting the recommendations of the CPT Panel in 2019 for continuing separate levels 2, 3, 4 and 5 for outpatient E/M visits. ASPN believes that separate levels more accurately reflect the work of caring for complex patients like those with pediatric chronic kidney disease, ESRD and transplant, for whose care pediatric nephrologists usually perform a level 4 and sometimes level 5 visit. We urge CMS to finalize this proposal as ASPN is confident the documentation requirements proposed by the CPT Editorial Panel will meet the agency's goal of reducing administrative burden along with better representation of the complex decision making that is required to manage a condition like pediatric chronic kidney disease. With respect to the RUC recommended values, ASPN believes the significant increases in values proposed for level 4 and 5 visits will better represent the complex work that our members deliver to their patients, and will also help to prevent the loss of access to care that would result from ongoing reduced valuation of this care.

Prolonged Service Add-On Code

ASPN supports the implementation of the prolonged service add-on code that may be used when providers choose to bill by time and exceed the time for a level 5 new or established E/M service. We believe it will be especially useful for pediatric nephrologists treating children who typically require extended visits for complex care management. We urge CMS to finalize the code descriptor and value for this service, as well as the policy that allows it to be billed multiple times if the time spent on the date of service warrants it.

Complexity Add-On Code

In the CY 2019 PFS, CMS finalized two complexity add-on services: one for primary care, and the other for certain types of specialty care including nephrology. This year, CMS is proposing to consolidate the two previously finalized services into GPCX1, a single complexity add-on code that is tied to the patient's condition rather than the type of primary or specialty care being received.

ASPN urges CMS to finalize this add-on code as proposed. In our comments on last year's proposed rule, we had recommended that CMS tie a complexity adjuster to the specific complexity of the patient rather than the work of certain specialties, in recognition that complexity is primarily driven by the patient's condition and underlying disease. Nephrology patients have the highest hierarchical condition category (HCC) scores, and as such, we believe this add-on code will help capture the complex work of nephrologists that is not reflected in the revised outpatient E/M services.

ASPN would like to point out, however, that CMS does not offer specifics on the patient requirements that must be met to bill GPCX1. ASPN requests clarification from the agency on the specific

circumstances when providers will be eligible to bill these services and what documentation must be included in the medical record.

Request for Comment on Revaluing Outpatient E/M Visits within Transitional Care Management (TCM), Cognitive Impairment Assessment/Care Planning and Similar Services

CMS identified a number of services that are closely tied to E/M values, including certain ESRD monthly services (CPT codes 90951-61) in addition to the other E/M code families and surgical global services for re-evaluation. The agency requests comment on how to adjust the RVUs for these services and on systemic adjustments that may be needed to maintain relativity between these services and outpatient E/M services.

ASPN appreciates that CMS recognized the ESRD monthly services as being closely tied to the outpatient E/M services that were used as building blocks in the valuation of these services. As part of ESRD care, our members typically manage more than just kidney disease. Kidney disease needing chronic dialysis in children overwhelmingly affects all aspects of pediatric care, so a pediatric nephrologist generally manages most medical comorbidities and oversees patient and family psychological well-being as well. All of this E/M-type work now included in the ESRD bundle is just as complex as that work included in outpatient office visits; therefore, we recommend that CMS apply increases to the ESRD monthly service codes proportional to those proposed for the outpatient E/M services reflect the care management and complexity of these ESRD services. We do not believe it is necessary for these services to be surveyed by the RUC.

CMS should apply similar documentation changes and increase the service values seen in the outpatient setting to the other E/M code families, specifically the inpatient codes. Our members typically bill E/M services in both sites of service and believe that these codes must also be addressed to appropriately reflect patient acuity and the additional time clinicians spend treating complex patients.

Care Management Services

CMS believes that care management services, including transitional care management (TCM) and chronic care management (CCM) services, have the potential to substantially improve patient outcomes if their utilization increases. To date, physicians have not been billing these codes regularly because the burdensome documentation required outweighed the financial benefit of their use.

ASPN supports the agency's efforts to increase the utilization of these services, as we agree that improved care coordination and management will improve patient outcomes. Specifically, CMS proposes to make a number of services that were previously considered to be overlapping with TCM services to be separately reportable. Included in that list of services are the ESRD services (CPT codes 90960-62, 90966, 90970) for patients who are 20 years of age and older. We support this proposal and urge CMS to make the ESRD services for patients under 20 years of age separately reportable as well. One-third of the pediatric ESRD patients treated by our members are covered by Medicare and will benefit from allowing their ESRD care to be billed along with the TCM services. It is not clear why CMS originally made the distinction between pediatric and adult patients with ESRD.

Principal Care Management

ASPN appreciates CMS's proposal to create a principal care management (PCM) service for the care management services delivered to patients with one chronic condition, and we recommend finalizing this proposal. This service will address a significant gap in the existing menu of care management, and we believe these services may be utilized by ASPN members treating patients with conditions like nephrotic syndrome or hypertension.

CMS does not provide detail about the documentation required to bill these proposed services. As we have seen with the TCM and CCM services, documentation requirements can drive providers away from utilizing certain services; thus, documentation should not be disproportionately complex compared to the reimbursement level for the service. ASPN urges CMS to articulate the types of patients and conditions to which this service will apply and to develop less burdensome requirements for PCM services than those that were originally developed for other care management services. These requirements should be designed to optimize the capabilities of electronic health records (EHRs) in collecting the required data.

Online Digital Evaluation Services (e-Visits)

ASPN supports the agency's proposal to pay for six new e-Visit codes to reimburse physicians and qualified non-physician healthcare professionals for the non-face-to-face work they routinely perform that includes a clinical decision that would typically be provided in the office. These services are patient-initiated digital communications that result in an online digital E/M service. We believe it is reasonable to make these services time-based, and we urge CMS to minimize the documentation required, as unduly burdensome documentation will be a disincentive to providers to appropriately bill for these services. We also recommend that CMS periodically revisit these services to make sure they reflect current practice patterns and EHR capabilities.

Quality Payment Program – Merit-Based Incentive Payment System

Measures Proposed for Removal

CMS is proposing to remove the following measure from the Merit-Based Incentive Payment System (MIPS) beginning with the 2022 payment year: Pediatric Kidney Disease: ESRD Patients Receiving Dialysis: Hemoglobin level <10 g/dl. The agency states its removal is proposed for several reasons: the measure does not align with the meaningful measure initiative; there is a limited patient population; adoption of the measures does not allow for the creation of benchmarks; and it was not reported in 2017.

ASPN recognizes that the agency's rationales may technically be correct, but still urge CMS not to remove this measure. Despite the small number of Medicare patients treated by pediatric nephrologists, many of ASPN members do not meet the low volume threshold and are still required to participate in the QPP. Very few measures exist in the Quality category that apply directly to the practice of pediatric nephrology. Last year, CMS removed another of the few pediatric nephrology-specific measures, leaving our members with even fewer measures to report. We urge the agency not to eliminate this or any other pediatric kidney disease measures from the Quality category unless and until they can be replaced with other measures specific to pediatric kidney disease.

Moreover, ASPN believes this measure still has significant clinical value to our members and the children we treat, since anemia is a problem of unique import in children with ESRD. There are significant data that show that children with Chronic Kidney Disease suffer increased morbidity and mortality in the setting of hemoglobin levels < 10 g/dL. Anemia also adversely affects growth and cognitive development in children and leads to reduced scores on quality of life metrics.

Thank you again for the opportunity to submit comments on the CY 2020 PFS proposed rule. Please contact our Washington representative, Erika Miller, at (202) 484-1100 or emiller@dc-crd.com, if we can provide additional information or clarification regarding ASPN's comments.

Sincerely,

A handwritten signature in blue ink, appearing to read 'P. Brophy', is enclosed within a thin black rectangular border.

Patrick Brophy, MD, MHCDS

President