

Dialysis Access Coding Essentials, Recent Changes, and Location Distinctions

The impact that current CMS reimbursement has had on the settings for dialysis access care and a look ahead at the forthcoming rate decisions.

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The Centers for Medicare & Medicaid Services (CMS) routinely analyzes CPT codes that are used together > 75% of the time and refers them to American Medical Association, CPT, and relative value update committees for revaluation and establishment of new bundled codes. In 2017, CMS created new bundled codes for the repair and maintenance of dialysis vascular access. The dialysis access codes that historically used component billing triggered that review. The specialty societies surveyed members for work values, and an expert group determined practice inputs. Those CPT codes (36901–36908) revalued and adjusted payments for these medically necessary services.

On average, a typical dialysis patient will require 1.9 vascular access encounters per year. The dramatic increase in endovascular maintenance performed in the extension of practice (EOP) physician office surgery center and the evidence of superior outcomes and lower cost¹ have created a national

network of approximately 300 freestanding, physician office-based “access centers.” The cut in the physician office payment was a combination of items, but the primary driver was the time for the procedure, which was significantly less than in the older codes. When the new codes came into the physician office fee schedule, it reflected that new value for the new codes.

The valuation method for the ambulatory surgery center (ASC) and hospital outpatient department (HOPD) is different from that for the Physician Fee Schedule. For the HOPD, the procedures are assigned ambulatory payment classifications that are groupings of similar codes for endovascular procedures. The ASC payment is cross-walked from the HOPD rate and discounted.

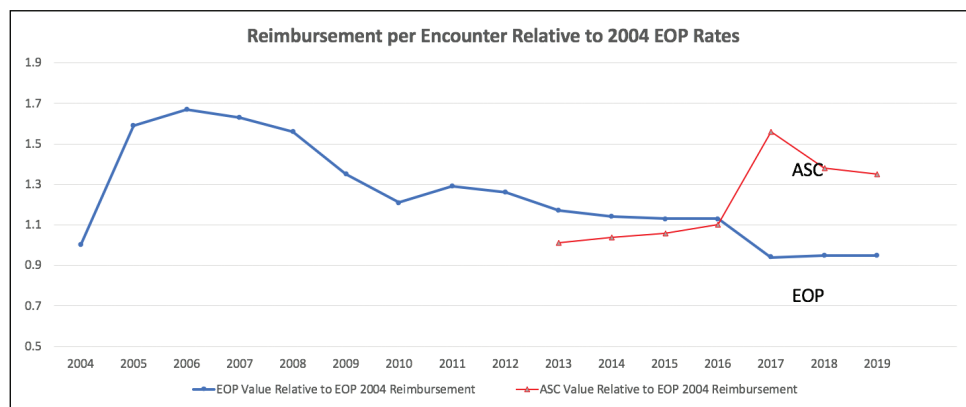


Figure 1. Vascular access outpatient reimbursement trend.

This valuation methodology difference is why the new codes are paid very differently, and the rate increase is consistent with CMS methodology. Despite some concerns about growing utilization, this was not a signal from CMS to create ASCs nor was it a penalty for physician office surgery centers, but merely the way CMS prices new code.

IMPACT OF THE 2017 CODES

The 2017 bundled codes for the repair and maintenance of dialysis vascular access brought about a significant strategic shift in the industry. The EOP setting experienced an approximate 39% decline, whereas the ASC setting saw an increase of about 40% for the same services. Few things illustrate the rapid decline of the physician office–based access center better than findings from the American Society of Diagnostic and Interventional Nephrology stating that nearly 20% of the freestanding centers for dialysis access had closed since the new codes were created.² Figure 1 shows the physician office reimbursement rates over time, where reimbursement is clearly lower as compared with 2004 rates.

The bundled codes have a payment variation that is quite dramatic by place of service (Figure 2). There is a rule at CMS related to office-based procedures performed in an ASC. If a procedure is performed > 50% of the time in a physician office, the ASC fee schedule will use the Physician Fee Schedule rate, not the ASC rate. For example, as noted in Figure 2, the angioplasty code is currently above the 50% level in the physician office, which would trigger a reduction in payment to the Physician Fee Schedule rate.

The growth of ASCs in this space is fueled by both reimbursement rates as well as the development of sophisticated hybrid models that allow the sharing of space to operate as both an EOP and an ASC in the same building. Early results from CMS show a gradual shift in site of service for dialysis access, with ASC growth outpacing other places of service. Overall, recent reports indicate a reduction in the number of procedures performed annually.

UPCOMING 2020 RATE CHANGES

As part of the “office-based” policy for the 2019 ASC Proposed Rule, CMS proposed to set the ASC rate for

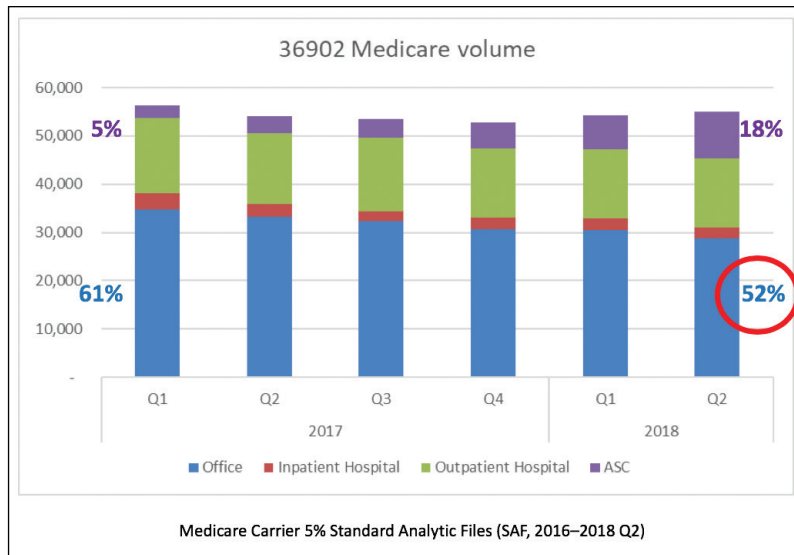


Figure 2. The dialysis angioplasty code used by site of service since the new codes were created. The trend shows an increasing number performed in ASCs and a declining number being performed in the physician office.

the key vascular access preservation code (36902) at the same rate set in the Physician Fee Schedule—a 62% reduction in reimbursement. This cut would have occurred on top of an existing 39% reduction set forth in the 2017 Physician Fee Schedule Final Rule. Although CMS did not enact the reduction in 2019, the final rule noted that angioplasty code 36902 would be analyzed this year. Table 1 shows the most recent analysis of volume of this code by the place of service.

The Dialysis Vascular Access Coalition is an active coalition composed of providers, medical specialty societies and associations, device manufacturers, patient groups, and other stakeholders who work together to educate both CMS and Congress on issues related to the importance of protecting patient access to these services outside of the hospital. The Medicare rates for 2020 will be published in July/August 2019, and this group has been hard at work laying the groundwork if the rates are targeted for further erosion. Please see the Dialysis Vascular Access Coalition website at <http://dialysisvascularaccess.org/take-action> for more information and to engage in this process.

In addition to the reductions in reimbursement, there have been some state-level actions, both with state Departments of Health and local Medicare intermediaries, that threaten the outpatient services for access care. Pennsylvania, Florida, and Louisiana have all proposed changes to the services currently provided outside of the hospital.

TABLE 1. DIALYSIS ACCESS REIMBURSEMENT BY SITE OF SERVICE FOR 2019

HCPCS	2019 Physician Office Global (Final)*	2019 HOPD Global (Final) [†]	2019 ASC Global (Final) [‡]	ASC Payment (%) Compared to HOPD	ASC Payment (%) Compared to Physician Office
36901	\$661	\$1,270	\$699	55%	106%
36902	\$1,301	\$4,931	\$2,255	46%	173%
36903	\$5,485	\$10,002	\$6,336	63%	116%
36904	\$1,914	\$5,067	\$2,391	47%	125%
36905	\$2,407	\$10,134	\$4,523	45%	188%
36906	\$6,724	\$15,892	\$10,263	65%	153%
36907	\$736	NA	NA	NA	NA
36908	\$2,451	NA	NA	NA	NA
36909	\$1,982	NA	NA	NA	NA

Abbreviations: ASC, ambulatory surgical center; HCPCS, Healthcare Common Procedure Coding System; HOPD, hospital outpatient department; NA, not applicable[§].

*Physician Fee Schedule nonfacility total.

[†]Hospital outpatient prospective payment system payment rate plus Physician Fee Schedule facility total.

[‡]ASC prospective payment system payment rate plus Physician Fee Schedule facility total.

[§]NA indicates that these codes are considered bundled/packaged into facility settings; no separate payment is available.

THE FUTURE OF DIALYSIS VASCULAR ACCESS SERVICES

There is no crystal ball to reference, but we know that dialysis patients will continue to need services to repair and maintain their permanent access. The place of service will likely continue to shift relative to payment. One key concept for the future is engagement of the patient, where the kidney community is far ahead of other specialty groups. The advent of innovative projects such as the US Department of Health and Human Services/American Society of Nephrology's KidneyX (Kidney Innovation Accelerator) project, this year's release of the updated National Kidney Foundation (NKF) Kidney Disease Outcomes Quality Initiative's vascular access guidelines, and disruptive new therapies that have either been approved or are in development (eg, percutaneous arteriovenous fistula creation) will foster new approaches and solutions for this fragile population.

The current Secretary of the US Department of Health and Human Services, Alex Azar, has a personal commitment to kidney care, as his father was on dialysis and received a kidney transplant several years ago. At the NKF Kidney Summit on March 4, 2019, he said, "Today, I want to lay out what it would look like to pay for kidney health, rather than kidney disease—and pay for Americans with kidney disease to actually get good outcomes, rather than the endless, life-consuming

procedures that you all know so well." His words are a battle cry in the kidney space and should inspire us to do more and engage our patients in this field. The challenge is ours to provide vascular access health for the nearly half a million Americans on dialysis for renal failure. ■

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1. El-Gamil AM, Dobson A, Manolov N, et al. What is the best setting for receiving dialysis vascular access repair and maintenance services? *J Vasc Access*. 2017;18:473-481.
2. Dialysis Vascular Access Coalition. Re: Medicare program; revisions to payment policies under the Physician Fee Schedule and other revisions to part B for CY 2018; Medicare shared savings program requirements; and Medicare diabetes prevention program (CMS-1676-P). <http://dialysisvascularaccess.org/wp-content/uploads/2018/03/DVAC-CY-2018-ASC-Final-Rule-Comment-FINAL-CONSOLIDATED-WITH-PFS-COMMENT.pdf>. Accessed May 31, 2019.

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