

encounters as suggested by MedPAC. However, we believe a change should be made in the interim to improve care and accountability. The use of these new codes will also enable us to collect data about the frequency of physician visits.

#### *Regulatory Impact of Proposal on SGR and Conversion Factor*

We received comments regarding the impact of these proposed changes on the sustainable growth rate (SGR) calculations. Commenters expressed concern that, if physician behavior changes and physicians increase the number of visits provided per month, actual expenditures would surpass the target projection, resulting in a future payment reduction for all of medicine.

*Response:* Section 1848(c)(2)(B)(ii)(II) of the Act requires that changes to RVUs cannot cause the amount of expenditures to increase or decrease by more than \$20 million from the amount of expenditures that would have been made if such adjustments had not been made. As indicated above, we have established RVUs for the new monthly capitation codes so that Medicare's aggregate payments for these services are equal to what we would have paid in the absence of these changes. We are not expecting any impact on payment for other physician fee schedule services. However, we will continue to review this issue as we work with the medical community to further refine Medicare policy for treating patients needing dialysis services.

#### *Home Dialysis*

Many comments were received regarding home dialysis because patients who dialyze at home typically see their physicians less frequently than other ESRD patients. One commenter suggested that home dialysis patients be excluded from the proposed change and that we continue to pay the current MCP rate for services to these patients.

*Response:* We have created four G codes for the management of home dialysis patients in each of the age groups and will pay for the home dialysis patients at the same rate as codes G0309, G0312, G0315, and G0318 respectively. Although the codes for home dialysis patients will pay physicians slightly less than the former MCP, physicians will still have a relative incentive to increase the use of home dialysis. We believe this is consistent with Section 1881(b)(3)(B) of the Social Security Act which states "With respect to payments for physicians' services furnished to individuals determined to have end stage renal disease, the Secretary shall pay 80 percent of the amounts

calculated for such services on a comprehensive monthly fee or other basis (which effectively encourages the efficient delivery of dialysis services and provides incentives for the increased use of home dialysis) for an aggregate of services provided over a period of time (as defined in regulations)."

The new G codes for the monthly management of home dialysis patients will be as follows:

G0320—End stage renal disease (ESRD) related services for home dialysis patients per full month; for patients under two years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents.

G0321—End stage renal disease (ESRD) related services for home dialysis patients per full month; for patients two to eleven years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents.

G0322—End stage renal disease (ESRD) related services for home dialysis patients per full month; for patients twelve to nineteen years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents.

G0323—End stage renal disease (ESRD) related services for home dialysis patients per full month; for patients twenty years of age and older.

The American Society of Nephrology also commented that "reimbursement should be constructed so that home dialysis patients should see their nephrologist at least monthly, with further visits on an as needed basis." We will not specify the frequency of required visits at this time but expect physicians to provide clinically appropriate care to manage the home dialysis patient.

If home dialysis patients are hospitalized during the month, four new G codes have been created: G0324, G0325, G0326, and G0327. These codes will be used to report daily management of home dialysis patients for the days the patient is not in the hospital. CPT codes 90922, 90923, 90924, and 90925 will be considered inactive for Medicare because they are now redundant as other codes are to be used by physicians billing for services to ESRD patients.

The new G codes are as follows:

G0324—End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients under two years of age.

G0325—End stage renal disease (ESRD) related services for home dialysis (less than full month), per day;

for patients between two and eleven years of age.

G0326—End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients between twelve and nineteen years of age.

G0327—End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients twenty years of age and over.

For example, if a home dialysis patient is in the hospital for 10 days (counting the calendar day of admission and the calendar day of discharge) and is cared for 20 days in his or her home, then 20 units of the code for the appropriate aged patient is billed.

If a home dialysis patient receives dialysis in a dialysis center or other facility during the month, the physician is still paid the management fee for the home dialysis patient and cannot bill the codes in the range of G0308 through G0319 or CPT codes 90935 or 90937, even though the physician may see the patient during his/her center dialysis.

#### *Role of Non-Physician Practitioners or Physicians Other Than the MCP Physician*

We received comments about the role of nonphysician practitioners. It was not clear to the commenters whether visits by these practitioners could count as face-to-face encounters by the MCP physician. The commenters also asked about billing by physicians (for example, a "rounding" physician or fellow) other than the physician who is billing the monthly capitation rate.

*Response:* Physicians may utilize nonphysician practitioners: nurse practitioners, physician assistants, and clinical nurse specialists, who are able under the Medicare statute to furnish services that would be physician services if furnished by a physician and who are eligible to enroll in the Medicare program, to deliver some of the visits during the month. The rules for the use of these physician extenders would be consistent with the rules for split/shared evaluation and management visits: The nonphysician practitioners and physician must be in the same group practice or employed by the same employer/entity; and the physician must perform some portion of the service in a face-to-face encounter, in this case one or more visits during the month with the patient. In this situation, to bill the service under the physician's UPIN/PIN, the physician and not the physician extender should be the practitioner to perform the visit with the complete assessment of the patient and to establish the patient's