

plan of care. If the nonphysician practitioner is the practitioner who performs the complete assessment and establishes the plan of care, then the MCP service should be billed under the UPIN/PIN of the nurse practitioner, physician assistant, or clinical nurse specialist.

It is also possible for the physician to use another physician to provide some of the visits during the month, but the physician who provides the complete assessment, establishes the patient's plan of care and provides the ongoing management should be the physician who submits the bill for the monthly service. The non-MCP physician must have a relationship with the billing physician such as a partner, employees of the same practice, or supervising physician and fellow doing sub-specialty training.

Each practitioner should document in a shared medical record services he/she personally performed. Only one practitioner can bill for the management of the ESRD patient in any month. In addition, when a nonphysician practitioner or a "rounding physician" sees a dialysis patient for management of ESRD, they cannot bill an evaluation and management service for the same patient unless there is a separate, substantial and documented service evaluating the patient for care unrelated to the patient's dialysis.

Geographic Issues

Commenters indicated that the lack of geographic considerations would negatively impact physicians and patients in rural and some urban settings where physician visits require significant travel time. Extended travel time can make it difficult for physicians to see patients as often as patients can be seen when the physician's office is near the dialysis facility.

Response: We believe that the policy to allow nurse practitioners, physician's assistants, clinical nurse specialists, and other physicians to deliver some of the visits to patients as well as changes in the payment to more accurately reflect non-visit services and the relative value of additional visits will ameliorate these access issues.

Lack of Clarity Regarding Hospitalization

Commenters noted that the proposed rule did not provide enough detail regarding alternative billing procedures if hospitalization occurs during the month.

Response: For ESRD patients (other than home dialysis patients) who are hospitalized during the month, the physician may bill the code that reflects

the number of face-to-face visits during the month on days when the patient was not in the hospital (either admitted as an inpatient or in observation status).

Documentation Requirements

Comment: Many commenters asked for clarification regarding the documentation requirements, if any, associated with the new codes.

Response: We have chosen not to include specific documentation guidelines in this rule. Instead, physicians should document what is clinically relevant, including but not limited to the patient's current status and complaints, a clinically appropriate physical examination, assessment of the patient's treatment for ESRD that includes assessment of the adequacy of the dialysis treatment, the status of the patient's vascular access, assessment and treatment of the other conditions associated with ESRD, such as anemia, electrolyte management, and bone density, as well as changes to the patient's management.

HIPAA Compliance

Comment: A comment was received that HIPAA transaction and code set rules may not be met if these new codes were implemented.

Response: G codes are part of the HCPCS coding system and are in compliance with the HIPAA transaction and code set rules.

Outpatient Settings

Comment: Commenters asked for additional clarification on whether visits counted toward the MCP can be provided in settings other than the dialysis facility.

Response: The visits for management of ESRD patients may occur in the physician's office, in an outpatient hospital or other outpatient setting or even in the patient's home as well as in the dialysis facility.

Transient Patients

Comment: Commenters inquired how physicians would deal with visits and related billing for traveling patients who receive their treatment away from their usual site of treatment.

Response: If the physician manages the care of a patient who is receiving treatment away from the patient's usual site of treatment, the physician who bills for managing the care of the patient is still paid according to the number of times the physician has a face-to-face visit with the patient. If the patient is to be away for an extended period of time, the patient would be managed by the physician who has face-to-face visits with the patient, and that physician

would be the one billing for the patient's care management.

Quality of Care and Outcomes

Comment: Commenters representing the American Osteopathic Association, the American Academy of Family Physicians, the National Coalition for Quality Diagnostic Imaging Services, the American Society for Echocardiography and Focus on Therapeutic Outcomes, Inc., provided information on quality initiatives their respective organizations have undertaken or suggestions for relating quality to payment. The National Kidney Foundation recommended the use of technology and other forms of communication to care for ESRD patients and to support constant attention to quality. In addition, the Society for Interventional Radiology commended our efforts to increase the use of arteriovenous fistulae for vascular access in dialysis patients as part of its National Vascular Access Improvement Initiative, but indicated there might be a need to clarify certain policies. The American Association of Kidney Patients (AAKP) also recommended the establishment of a commission or advisory group with representation of the kidney community that could be charged with recommending proposals to tie reimbursement to outcomes. AAKP stated that although the proposed changes are important, these changes remain a change in process of delivery of care that may improve actual outcomes, rather than a change in actual outcomes, that is, in rehabilitation, morbidity, mortality, and quality of life. MedPAC agreed with CMS that the proposed change to provide incentives for additional nephrologist-dialysis patient interactions may not be the ideal method to improve patient outcomes and to achieve this goal, CMS should partner with the ESRD community and work toward a long-term solution. MedPAC suggested that we investigate and incorporate physician clinical practice guidelines into our payment approach, and measure physician quality directly. MedPAC also suggested that we examine whether physician resources vary based on patient complexity, stating that to the extent that resources do vary, a case-mix adjustment—similar to the one MEDPAC recommended for payment to dialysis facilities in its June 2003 report—would be desirable.

Response: We appreciate the information and suggestions provided by the commenters and will take these into consideration. We plan to investigate the use of new technology to improve the management of ESRD