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# Highlights from the 2025 Medicare Fee Schedule: Mostly Neutral for Nephrology, RVUs Slightly Increased, Certain Dental Services for ESRD Patients Now Covered

On November 1, the final rule for the 2025 Medicare Physician Fee Schedule (MFS) was released. As in recent years, the news was mostly neutral for nephrology. Relative Value Units (RVUs) for most services commonly provided by nephrologists experienced slight increases, the G2211 complexity add-on code introduced in 2024 has been expanded for 2025, and CMS has provided coverage for certain dental services for ESRD beneficiaries for the first time, all of which is positive news.

The most pressing issue overshadowing all of this is the status of the 2025 fee schedule conversion factor (CF), which is (1) scheduled for a 2.9% reduction, (2) expected to be addressed by Congress by the end of 2024, and (3) still unresolved at press time. RPA will provide updates on the adjudication of the CF issue as developments occur. The current context of Congressional consideration on this topic is discussed in the "From Capitol Hill" section on page 3.

The major provisions of the rule are outlined below, beginning with the coverage and reimbursement issues, followed by the quality measurement updates included in the rule.

## Coverage and Reimbursement Provisions

### Physician/Nephrologist Payment

Per CMS, "the 2025 conversion factor (CF) will be reduced by 2.93% in CY 2025, compared to the average amount these services were paid for most of CY 2024. This amounts to an estimated CY 2025 PFS conversion factor of $32.35, a decrease of $0.94 (or 2.83%) from the current CY 2024 conversion factor of $33.29." As previously reported, Congress is expected to address the shortfall by year's end.

Nephrology overall is expected to have a valuation (i.e., RVU) impact of 0% but CMS parses this out farther and says it will be a +1% impact in the non-facility (outpatient) setting, and a 0% impact in the facility (inpatient) setting. This is borne out by the service codes commonly billed by nephrology, with most of the dialysis (inpatient and outpatient) codes staying even or ticking up a hair. The same is true for E&M codes, with slight decreases in value for the two high volume dialysis circuit (interventional) codes.

For example, while the total RVUs for CPT code 90935 (hemodialysis, single evaluation) remained steady at 2.10, the RVUs for CPT code 90960 (adult monthly ESRD services, 4 visits) were increased from 10.50 to 10.60, and the RVU's for CPT code 90966 (adult monthly home dialysis) were increased from 8.72 to 8.80. Similarly, the RVUs for the high-level evaluation and management (E&M) codes were increased, albeit very slightly.

Additionally, the total RVUs for CPT code 99204 (level 4 office visit, new patient) were increased from 5.02 to 5.05, and the total RVUs for CPT code 99214 (level 4 office visit, established patient) were increased from 3.85 to 3.87.

The less positive news is that the two high volume dialysis circuit code were reduced, as expected. CPT codes 36902 (angiogram with angioplasty) and 36905 (declotting procedure with angioplasty) were each reduced by 3%. 2025 is the last year of the four-year transition reduction due to clinical staff RVU reallocation, so presumably these values would hold steady in future years.

In its analysis of the specialty-specific impact from the proposed rule this summer the American Medical Association (AMA) estimated that the reduction for nephrology would only have been -2.1%, compared to a 2.93% cut overall. Of course this is still a cut, but indicative of the incremental increase in RVUs for services typically provided by nephrologists. As always, RPA monitors the values for nephrology-centric services as necessary and advocates for appropriate valuation, as necessary.

### G2211 Complexity Adjuster

CMS finalized its proposal to pay for G2211 with modifier -25 when it is "is reported by the same practitioner on the same day as an annual wellness visit (AWV), vaccine administration, or any Medicare Part B preventive service, including the Initial Preventive Physical Examination (IPPE), furnished in the office or outpatient setting."

To be clear, this is an expansion of the use of the G2211 code, and in addition to the new options for use with modifier -25, it can still be used in the same manner with E&M service codes

*continued on page 2*

*"Highlights from the 2025 Medicare Fee Schedule" continued from page 1*

when the nephrologist is providing longitudinal care to a complex patient, as in 2024. [see Coding Corner on page 17 for additional information]

### Dental Services for ESRD Patients

CMS also finalized its proposal to pay for certain dental services for ESRD/dialysis patients, stating: "Medicare payment may be made for dental services inextricably linked to covered services, to include: (1) dental or oral examination in the inpatient or outpatient setting prior to, or contemporaneously with, Medicare-covered dialysis services for the treatment of end-stage renal disease and (2) medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to, or contemporaneously with, Medicare-covered dialysis services for the treatment of end-stage renal disease."

RPA and several other groups in the kidney care community advocated vigorously for the extension of dental coverage to all ESRD beneficiaries subsequent to similar coverage being provided to Medicare Part B-ID (for immunosuppressive drugs) beneficiaries several years ago, so this is a definite positive step forward for kidney patients and practitioners.

### New APCM Service Codes

CMS also finalized its proposal to pay for Advanced Primary Care Management (APCM) services. Level 1 (G0556, with a projected payment in the proposed rule of about $10) is for persons with one chronic condition; Level 2 (G0557, with a projected payment in the proposed rule of about $50) is for persons with two or more chronic conditions; and Level 3 (G0558, with a projected payment in the proposed rule of about $110) is for persons with two or more chronic conditions and status as a Qualified Medicare Beneficiary.

While CMS highlights chronic kidney disease (CKD) as a condition for which they expect the APCM services would be provided, its use in CKD care is yet to be determined as CMS will only pay for one claim monthly for APCM services, and primary care and other subspecialists who comprise a nephrology practice's referral base may also seek to bill for these services.

### Telehealth

- On telehealth, CMS finalized the following:
  - Beginning January 1, 2025, an interactive telecommunications system may include two-way, real-time, audio-only communication technology for any Medicare telehealth service furnished to a beneficiary in their home, if the distant site physician or practitioner is technically capable of using an interactive telecommunications system, but the patient is not capable of, or does not consent to, the use of video technology.
  - Through CY 2025, CMS will continue to permit distant site practitioners to use their currently enrolled practice locations instead of their home addresses when providing telehealth services from their home.
  - And, for a certain subset of services that are required to be furnished under the direct supervision of a physician or other supervising practitioner, to permanently adopt a definition of direct supervision that allows the supervising physician or practitioner to provide such supervision via a virtual presence through real-time audio and visual interactive telecommunications.

To be clear, Congress still has to act to address the telehealth originating site and geographic restriction flexibilities in place until 12/31/2024. All indications are that this will occur as part of a year-end Medicare package as there is little disagreement on Capitol Hill about extending the benefit, but at press time it had not occurred.

### Compounded Immunosuppressive Drugs to be Included in the Part B-ID Benefit

CMS finalized a proposal to reduce barriers faced by beneficiaries receiving immunosuppressive drugs under the Medicare Part B-ID benefit, including policy barriers related to compounded immunosuppressive drugs. The key passage specially finalized policy to:

> *...Include orally and enterally administered compounded formulations with active ingredients derived only from FDA-approved drugs where approved labeling includes an indication for preventing or treating the rejection of a transplanted organ or tissue, or for use in conjunction with immunosuppressive drugs to prevent or treat rejection of a transplanted organ or tissue or have been determined by a MAC to be reasonable and necessary for this purpose.*

RPA supported this issue in **our comments on the July proposed rule** as pediatric dialysis patients are particularly affected by these policy complexities. As such, this policy affecting immunosuppressive drugs covered under the Part B-ID benefit represents a positive step forward.

***continued on page 3***

INSIDE THIS ISSUE...





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# It Ain't Over 'Til It's Over, Version One Million and Counting

The phrase "it ain't over 'til it's over" resonates in so many ways in our lives. Lenny Kravitz captured this sentiment in 1991 with his hit song "It Ain't Over 'til It's Over," which climbed to number two on U.S. and global record charts, becoming a background mantra for many during that time. Yogi Berra famously added to his mythology by coining the phrase in 1973, when his New York Mets, despite a middling 82-79 record, nevertheless won the National League East title and advanced to the pennant before falling to the Oakland A's in the World Series. (Speaking of the A's, it sadly seems "over" for them in Oakland, as they are slated to move to Las Vegas for the 2025 season. Sigh.) Sports consistently offer examples of outcomes that appear certain, only to be dramatically overturned.

Naturally, this concept applies to any situation involving competitive stakes, including the political arena, which brings us to the 2024 election. Leading up to November 5, the prevailing belief was that while margins would be razor-thin regardless of the outcome, the Senate would revert to Republican control due to a highly favorable electoral map. Meanwhile, Democrats were thought to have a slight edge in the races for the White House and leadership of the House of Representatives. However, as we now know, the latter two legs of the election stool did not go according to conventional wisdom.

Why this happened will be debated for decades. While Vice-President Kamala Harris and Democrats had distinct fundraising advantages and seemingly much momentum, vibes aren't votes, and overcoming the historically poor favorability ratings of the Administration in which she worked proved to be too much for her campaign to prevail.

It has also been suggested that Democrats were tactically "fighting the last war," while Republicans leveraged online strategies in a more comprehensive and effective manner. It certainly helps when the world's richest person, who owns one of the largest social media platforms, offers their full support—and President-Elect Trump's campaign undeniably benefited from that advantage. Regardless, the GOP now holds total control of Washington for at least the next two years. While its leadership will not formally take office until January, the impact of the November results is already being felt.

For example, what happens in December 2024 on many of the issues that RPA and organized medicine care about will depend on how FY 2025 appropriations/government funding is resolved. What seems to be a likely and logical path is for an omnibus bill (or a 'cromnibus' bill, where a continuing resolution—CR—is combined with an omnibus bill) is passed

*continued on page 4*

*"Highlights from the 2025 Medicare Fee Schedule" continued from page 2*

## Quality Measurement Provisions

**Regarding the quality payment program (QPP), the rule finalized the following:**

- CMS finalized the Alternative Payment Model (APM) Performance Pathway (APP) Plus quality measure set. The APP Plus Quality Measure Set is an optional measure set for MIPS eligible clinicians, groups, and APM Entities that participate in a MIPS APM, but required for Shared Savings Program ACOs. Beginning with the CY 2025 performance period/2027 MIPS payment year, the APP Plus Quality Measure Set will initially consist of the 5 measures in the existing APP quality measure set that are also Adult Universal Foundation measures, plus Quality Measure #112: Breast Cancer Screening, for a total of 6 measures. Additional measures will be added in subsequent years.
- CMS finalized maintaining the MIPS performance threshold at 75 points. RPA, along with much of the medical community, supported CMS' proposal to maintain the current MIPS performance threshold.
- CMS finalized their proposal to remove activity weighting from Improvement Activities. Now MIPS participants with the small practice, rural, non-patient facing, or health professional shortage area special status must attest to 1 activity, while other MIPS participants will attest to 2 activities. Those participating in an MVP will attest to 1 activity.
- Additionally, two new kidney-related quality measures were finalized:
  - Measure 510: First Year Standardized Waitlist Ratio (FYSWR)
    Description: The number of newly initiated patients on dialysis in a practitioner group who are under the age of 75 and were either listed on the kidney or kidney pancreas transplant waitlist or received a living donor transplant within the first year of initiating dialysis.
  - Measure 511: Percentage of Prevalent Patients Waitlisted (PPPW) and Percentage of Prevalent Patients
    Description: The measure tracks dialysis patients who are under the age of 75 in a practitioner group and on the kidney or kidney-pancreas transplant waitlist (all patients or patients in active status).

RPA has previously opposed these measures as being outside of the control of the nephrologist.

## Summary

While the 2025 Medicare Fee schedule included several policy victories from a kidney care perspective, adjudication of the 2025 conversion factor and extension of the telehealth flexibilities must be done by Congress; this is expected to happen. RPA will report on these developments as they occur.

*"From Capitol Hill" continued from page 3*

before the current funding deadline of December 20. This would ideally include telehealth extension, Medicare physician reimbursement relief, and perhaps other priorities such as prior authorization legislation, the living organ donor bill, and maybe even the orals-only drug bill.

However, with leadership shifting slightly toward the fiscal hardline side of the ideological spectrum, this outcome is far from guaranteed. Fiscal conservatives like those in the House Freedom Caucus (HFC) abhor omnibus bills and find sympathetic allies in House Speaker Mike Johnson (R-LA) and Mr. Trump. Ultimately, the decision boils down to which undesirable outcome these leaders are willing to accept.

If their fiscal instincts prevail, an omnibus bill would be rejected in favor of a continuing resolution (CR) to fund the government for three to six months. While this would satisfy the hard-right flank, it would also mean revisiting all appropriations bills in early 2025, delaying the Trump Administration's ability to advance its priorities. This happened in 2017, which some blame for the slow pace of the administration's initiatives at the time.

Should this approach be repeated, it is likely that three- or six-month extensions for telehealth and physician payment fixes would be included. On the other hand, passing an omnibus bill despite the perceived distaste, would make most of the GOP caucus happy (as most Republican legislators do favor addressing these issues in an omnibus), address constituency concerns (such as those regarding telehealth and physician payment), and clear the decks for 2025, allowing the administration to focus on pursuing its policy goals.

Another complicating factor for December is the unresolved status of broader issues such as disaster relief, the farm bill, defense authorization, and the potential enactment of a foreign aid package. These are relatively tectonic issues that typically fall into the "must-do" category, but with normal legislative processes disrupted, it remains unclear how they will be addressed.

For instance, the farm bill is traditionally passed in five-year increments; however, the prevailing chatter in Washington suggests that a one-year bill may be enacted before the year's end. While this would provide a temporary resolution for the Hill GOP, it would also leave a substantial project to tackle at the close of 2025.

For these large-scale, "aircraft carrier" issues, the next two years will be an interesting case study on whether the Trump Administration can fundamentally recast how such matters are considered. Naturally, this is likely their intention, but powerful and well-funded interests may prefer to maintain the current status quo regarding the government's approach to their concerns.

With respect to RPA's priorities and the broader balance of organized medicine, advocacy efforts have, paradoxically, been stronger than ever in some areas. However, it remains uncertain how these efforts will shape the discourse in the weeks, months, and years ahead. For example, regarding Medicare physician reimbursement, two bills aimed at tying payment to the Medicare Economic Index—H.R.2474 (the Strengthening Medicare for Patients and Providers Act) and its successor, H.R.10073 (the Medicare Patient Access and Practice Stabilization Act of 2024)—garnered impressive co-sponsorship numbers, with 172 and 58 supporters, respectively (the latter achieved in just a few weeks).

Additionally, a "Dear Colleague" letter in the Senate advocating for a physician payment fix secured 41 cosigners within weeks. On our end, the RPA grassroots alert on this issue in late November achieved our highest response rate in a decade. These robust advocacy efforts reflect strong legislative momentum; however, as noted, the issue may become entangled in complexities tied to broader governing philosophies.

A similar outlook applies to efforts aimed at improving living organ donation. The primary legislative initiative in this area, the Living Donor Protection Act (S.1384/H.R.2923), has also achieved remarkable co-sponsorship numbers—43 in the Senate and 221 in the House—along with a zero score (or cost estimate) and minimal opposition. Yet, much like physician payment reforms, this initiative is caught in the broader procedural and legislative mechanics, relying heavily on committed champions and a suitable legislative vehicle to advance.

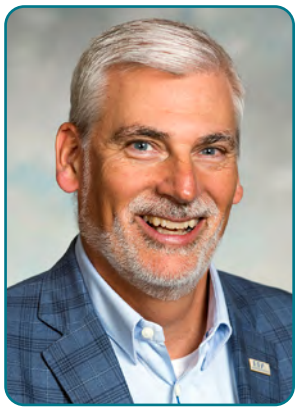
And then there is the issue of extending current telehealth flexibilities. This presents a particularly unique and dynamic challenge. As recently as the week before Thanksgiving, there was near-unanimous agreement on Capitol Hill that a telehealth extension was likely, potentially lasting two years. This bipartisan consensus spanned both chambers and included input from key staff in House leadership, Senate leaders, junior backbenchers, and everyone in between. It is widely agreed that neither Medicare nor the broader medical community should revert to the restrictive telehealth policies that existed before the public health emergency. However, as with physician payment reform and living organ donation efforts, uncertainty remains as to whether the extension will last three months, six months, a year, two years—or, in the worst-case scenario, not happen at all.

Regarding other key issues for medicine and nephrology, prior authorization (PA) legislation (S.4518/H.R.8702, the Improving Seniors' Timely Access to Care Act of 2024) and the bill renewing the exclusion of oral-only drugs from the ESRD Prospective Payment System (PPS) bundle (S.4510/H.R.5074, the Kidney PATIENTS Act) both have a "puncher's chance" (to borrow a boxing term for an outside shot) of advancement. Their fate likely hinges on the passage of a broader legislative package, serving as the last train leaving town before the new Administration and GOP flex their policy muscles, which as noted seems improbable but is not impossible

This brings us back to the central theme of this column: it ain't over 'til it's over. Influential lawmakers from both parties in the House and Senate are pushing for action on several key priorities, including a comprehensive farm bill, meaningful disaster relief, critical defense spending, and, more directly relevant, a telehealth extension and a physician payment bill, among others. As a result, legislation addressing these issues may still come to fruition. RPA will continue to provide updates on the resolution of these matters as they unfold.

Wishing you a safe and healthy new year!

# How Far Can a Lame Duck Fly? Navigating the 2025 Medicare Fee Schedule Cuts



Keith Bellovich, DO
RPA President

As renal professionals dedicated to providing high-quality healthcare, the 2025 Medicare Fee Schedule cuts pose significant challenges that jeopardize both the sustainability of our practices and the quality of care our patients receive. These persistent reductions have reignited concerns across organized medicine, underscoring the need to persistently advocate for our patients. The urgency of achieving reform and sustainable solutions is critical, especially in the context of a lame-duck Congress.

## The Scope of the 2025 Cuts

The 2025 Medicare Fee Schedule includes a series of reductions across various medical services. For many specialties, these cuts represent a sizable decrease in reimbursement rates, compounding the financial pressures already present due to inflation, increased operating costs, and recent global economic disruptions. The Medicare conversion factor is scheduled for a 2.9% reduction, and depending on how a specialty's RVUs are affected, this cut could be substantially higher. While nephrology's impact is slightly better than some other specialties, our dependence on Medicare as a payer means that we have fewer privately insured patients to make up for cuts in Medicare payment.

## What risks does this pose?

### Access to Care:

The most immediate risk is reduced access to care. Over the past two decades, reimbursement rates have continually declined, amounting to an approximate cumulative reduction of 30% when adjusted for inflation. While there has been a shift in services from procedural specialties to primary care, nephrology remains disproportionately affected due to the complexity of preventative care required under new payment models. Nephrology relies heavily on the smaller practices—particularly those in rural or underserved areas—to provide for our patient base. A reduction in healthcare availability would disproportionately impact vulnerable populations who already face significant barriers to accessing quality care.

### Quality of Care:

Reduced funding could also lead to a strain on resources, including staff and technology. Overworked personnel and outdated or insufficient medical equipment hinder our ability to provide the highest standard of care. Moreover, longer wait times for patients have become inevitable as practices struggle to manage increased workloads with fewer resources.

### Innovation and Continuing Education:

Cuts continue to stifle innovation in our field. Sadly, outdated payment systems cause our patients to lose out on investment in new technologies and research that is so desperately needed in order to make inroads into long term solutions to kidney care.

For practitioners, especially in our field that is so heavily reliant on Medicare, visiting the Hill with hat in hand is the last resort, but under these continual declines it's beyond time to sound the alarm. Given the ageing nephrology workforce, it has become imperative that we acknowledge the importance of creating an encouraging forecast for new potential trainees in our field. Without sustainable solutions, we risk deterring the next generation of healthcare providers, exacerbating current and future shortages in nephrology and medicine at large.

## Don't Take Your Foot off the Gas

In spite of our fatigue from a long and competitive election season, we need to continue to engage our departing lawmakers but also optimistically welcome our new congressional members.

I can assure you, we at RPA will continue to independently advocate and collaborate with the rest of organized medicine to drive these necessary fixes and allow these lame ducks to land safely.

We need your continued engagement with RPA to keep everyone informed. Thank you!

Scan the QR code to make your donation to the RPA PAC today!

# A Year Well Served

Adonia Calhoun Groom, CAE, CMP
RPA Executive Director

RPA's 50th anniversary proved to be a resounding success. Labeled 50 years of excellence in nephrology, the year was marked by celebration, reflection, extensive engagement, and forward-looking preparation for growth.

The RPA Annual Meeting and 50th Anniversary celebration left attendees eager for more. The event addressed many of the key issues facing kidney professionals The **RPA Anniversary documentary videos and interactive historical timeline** took a look back at the impact and importance of RPA to the profession. Networking opportunities revealed hidden musical talents during karaoke and showcased the community's lively spirit on the dance floor at the celebratory banquet. The meeting concluded with attendees feeling fulfilled and enthusiastic about the upcoming 2025 Annual Meeting, scheduled for April 3–6, 2025, in Las Vegas, Nevada. Don't miss this exciting event. **Registration is open now**.

The first year of the RPA strategic plan was marked by research, analysis, and process improvements.

**Goal One: Pursue Inclusive Expansion** involved staff and leadership in discussions aimed at establishing a baseline understanding of opportunities to enhance inclusiveness within RPA. Internal and external process improvements focused on increasing outward communication and creating more opportunities for member participation and feedback, fostering greater transparency, awareness, and engagement with the association's efforts and initiatives.

**Goal Two: Innovate to Thrive** led to website enhancements to improve navigation, consultancy efforts to evaluate stakeholder relations, and an overall review of RPA initiatives. This review resulted in the discontinuation of programs with minimal participation or those that no longer provided a meaningful return on investment in terms of staff and financial resources.

**Goal Three: Champion a Sustainable Profession** saw RPA updating its governance processes and resources to expand participation and reach, not only for RPA but also for the RPA Dale Singer Leadership and Education Foundation and the RPA Political Action Committee (PAC). Throughout the year, RPA engaged in meaningful discussions with sister societies, partners, and legislative and regulatory bodies to address issues such as workforce shortages, health equity, payment policies, transplant policy, diagnosis code creation, and collaborative advocacy strategies.

In the second year of the strategic plan, RPA will continue implementing infrastructure adjustments, introducing new and expanded education and volunteer opportunities, enhancing communication through website and marketing assessments, and strengthening relationships and collaborations with stakeholders.

RPA governance groups and affiliates play a vital role in fostering community engagement and providing collective thought leadership to address strategic goals, challenges, and opportunities for both RPA and the broader kidney community. These groups typically convene several times a year and respond to initiatives and requests as they arise. Below is a brief, though not exhaustive, overview of RPA governance efforts in 2024:

- The RPA Board of Directors, chaired by President Keith Bellovich, met quarterly to address the state of the profession and critical policy issues affecting the delivery of high-quality kidney care. The board engaged stakeholders in meaningful discussions to tackle challenges and explore opportunities in kidney care delivery, advanced progress on strategic initiatives, participated in educational efforts to enhance understanding, awareness, and the significance of conscious inclusion, and oversaw the overall management and fiscal health of the organization.
- The RPA Clinical Practice Committee dedicated the year to addressing numerous requests for RPA's perspective and expertise. Key activities included engagement with ABIM initiatives related to longitudinal knowledge assessment (LKA) and a pilot program for international medical graduates, examining the impact of Medicare Advantage on nephrology, exploring updates to the RPA CKD toolkit, and discussing considerations for a hyperkalemia algorithm.
- The RPA Education Committee devoted the year to finalizing plans for the 2024 Annual Meeting and organizing the agenda for the 2025 Annual Meeting. With the introduction of new educational formats, a continued emphasis on networking, a commitment to supporting work-life balance, a coding and billing workshop, and the return of a medical director pre-meeting workshop, the RPA 2025 Annual Meeting is well-positioned for success.
- The Government Affairs Committee concentrated on RPA's 2024 legislative priorities, including Medicare Part B payment reform to address both 2024 shortfalls and longer-term system restructuring, the extension of alternate payment model bonuses, several legislative initiatives to promote living organ donation, and comprehensive kidney disease legislation. Additional efforts and advocacy this year focused on the Kidney Patient Act, the Retroactive Trend Adjustment (RTA) in the voluntary kidney payment models, changes to the ETC for 2025, transplant policy, planning for RPA Capitol Hill Day, activation of the RPA PAC, and more.
- The Health Care Payment Committee focused on monitoring and supporting efforts related to kidney code creation, proposed payment rules and changes, updates to kidney payment models, and RPA's participation in the CPT Editorial Panel and RUC. Additional priorities included work on Medicare Advantage with CPC, telehealth extensions, ETC mandatory models, and

*continued on page 7*

*"Executive Director's Perspective" continued from page 6*

advancements in value-based care, with particular attention to challenges and incentives across various payment systems and models.

- The Quality, Safety, and Accountability Committee set their sights on monitoring and supporting the development of quality measures in nephrology, particularly through participation in the Partnership for Quality Measurement committees. The committee also submitted comments on the quality section of the 2025 Medicare Fee Schedule and other quality measure requests, contributed to health equity initiatives through the Kidney Community Health Equity Summit, and represented RPA in the Advancing Kidney Health through Optimal Medical Management Collaborative.
- The Practice Managers Committee spent the year developing important content for the business management track during the RPA Annual Meeting, determining their committee leadership succession plan, education gaps and opportunities, increased engagement outside of the RPA Annual Meeting, and RPA benchmarking survey planning.
- With regard to the Committees of the RPA Board of Directors:
  - The Corporate Patrons Committee met with RPA patrons, discussing challenges and opportunities to improve patient outcomes and the delivery of high-quality care.
  - The Executive Committee engaged in bi-monthly meetings to discuss overall association management and initiatives of importance in between Board of Directors meetings.
  - The Finance Committee met to review and recommend approval of the RPA annual audit and budget.
  - The Nominating Committee met to assess recruitment processes, discuss, and recommend candidates for the RPA Board of Directors, RPA First Look Fellows program, and the RPA Leadership Development program for Early Career Nephrologists.
- The RPA Dale Singer Leadership and Education Foundation Board of Directors updated the bylaws of Foundation, supported the creation of Foundation Board process manual, expanded Board leadership to include public members, and discussed efforts to expand the Foundation's impact. We invite you to **donate to the RPA Foundation now**.
- The RPA Political Action Committee (PAC) Board of Directors met to discuss expanded efforts for the PAC and welcomed the new Board Chair Cindy Corpier.

RPA rounds out governance activities with purpose-driven task forces and workgroups designed to address time-sensitive or emerging issues. We are deeply grateful to all our volunteers for their dedication, time, and expertise in supporting the organization and the broader kidney community. RPA Committees are open for members to join year-round, with in person engagement during the RPA Annual Meeting. To learn more about RPA governance group charges, leadership, and how to join, **please visit our website**.

The RPA staff continues to operate as a small but highly effective team, with over 100 years of collective tenure. Our team is deeply passionate and dedicated to serving the needs of our members and the kidney community. A heartfelt thank you to Amy, Armeana, Desiree, Katrina, Mary, Rob, Rose, and, of course, me as we worked tirelessly to support our members, pursue growth opportunities for the organization, and strengthen relationships in alignment with RPA's vision for optimal kidney care for all. Thank you to our members, stakeholders, and partners. The RPA staff and leadership look forward to continuing to serve you in 2025!

## RPA 2024-2028 STRATEGIC VISION

**RPA MISSION:** EMPOWERING THE KIDNEY COMMUNITY THROUGH EDUCATION AND ADVOCACY

**RPA VISION:** OPTIMAL KIDNEY CARE FOR ALL

### RPA VALUES

| Inclusion | Integrity | Collaboration | Advancement | Agility |
|---|---|---|---|---|
| A welcoming home for the nephrology community. | Trust, ethics, and accountability above all. | Leveraging the power of partnerships. | Fostering professional growth and care delivery. | Identify, adapt, and act. |

### RPA STRATEGIC PRIORITIES

| Pursue Inclusive Expansion: | Innovate to Thrive: | Champion a Sustainable Profession: |
|---|---|---|
| Become the home for all professionals passionate about kidney care. | Advance our ability to serve our members. | Shape the future delivery of kidney care. |

# Positive Changes Coming to KCC for PY 2025

In late November, the Centers for Medicare and Medicaid Innovation (CMMI) announced several changes to the Kidney Care Choices (KCC) voluntary kidney payment models, which were widely welcomed by the nephrology and kidney care delivery communities. The Agency stated that these changes were made in response to feedback from model participants during meetings, quarterly calls, and the value-based care in-person conference earlier in 2024.

Key updates include the exclusion of expenses for new and innovative drugs (TDAPA) and equipment (TPNIES) from financial calculations, adjustments to account for dealignment in financial guarantees, and the introduction of an advanced shared savings program to provide participants with prospective assistance for upfront costs. CMMI stated that these are the final major updates they anticipate making to the model during its remaining two years. These changes address longstanding concerns raised by RPA and the broader kidney care community since the model's inception.

The chart below summarizes CMMI's current policy, the updated policy, and the rationale for the changes, categorized by issue area and specific modifications.

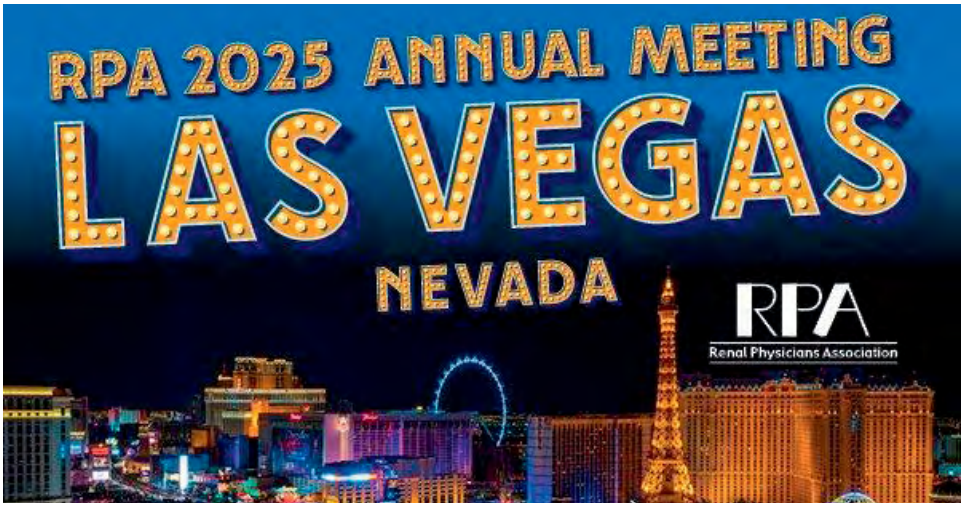
RPA will continue to monitor and analyze the developments and results of the KCC voluntary kidney payment models, particularly focusing on what they mean for nephrology practice and value-based kidney care. Members should contact RPA Director of Public Policy, **Robert Blaser**, with any questions.

| CURRENT KCC POLICY | UPDATED POLICY FOR PY 25 | CMMI RATIONALE FOR CHANGE |
|---|---|---|
| **PARTICIPANT MANAGEMENT** | | |
| **85% Dialysis Facility Ownership Requirement** | | |
| Require 85% or more of the dialysis facilities owned by the organization in the Kidney Contracting Entity's (KCE's) Market Area to participate in the model. | Remove the 85% requirement. | Dialysis facilities have no role for alignment in the model and we have heard this requirement inhibits certain care patterns. |
| **Update Service Area Definition** | | |
| The KCE's service area and any Core-Based Statistical Area (CBSA) that are contiguous to the KCE's service area. | Consider all CBSAs in Alaska contiguous to Washington, all CBSAs in Hawaii contiguous to California, and all CBSAs in Puerto Rico contiguous to Florida. | Current definition is detrimental to KCEs located in Hawaii, Alaska, and Puerto Rico, as those states and territories are not contiguous to another state or territory.<br>Updated policy will facilitate partnerships with the nearest state and encourage greater provider participation in the model. |
| **FINANCE** | | |
| **Exclude New and Innovative Drugs & Equipment (TDAPA/TPNIES) from Financial Calculations** | | |
| Total cost of care for beneficiaries for all Part A/B expenditures included in financial calculations. | Exclude TDAPA & TPNIES from financial calculations, such as benchmark, PY expenditures, and United States Per Capita Cost (USPCC) trend rates. | Excluding these expenditures could increase access to these treatments, improve quality of care, and avoid any disincentive to use these new treatments. |
| **Update CKD CPT Codes (Finance and Alignment)** | | |
| Inclusion of prolonged physician service codes 99354 and 99355 for CKD beneficiaries' alignment and financial calculation/payment. | Replace CPT codes 99354 and 99355 with 99417 for alignment and financial calculation/payment. | CMS retired CPT codes 99354 and 99355 for prolonged services and replaced them with CPT code 99417. |
| **PAYMENT** | | |
| **Update Financial Guarantee (FG) Calculation** | | |
| Use prospective alignment to calculate benchmark totals which does not account for previous performance year's de-alignment rate. | Include previous performance year's de-alignment rate in calculating financial guarantee amount, capped at 35% maximum rate. | Financial Guarantee (FG) Amounts are calculated prior to the start of the PY, using the prospective alignment methodology, without accounting for beneficiaries who will end up de-aligned.<br>This updated methodology recognizes updated alignment that occurs throughout the year. |

*continued on page 9*

*"Positive Changes Coming to KCC for PY 2025" continued from page 8*

| CURRENT KCC POLICY | UPDATED POLICY FOR PY 25 | CMMI RATIONALE FOR CHANGE |
|---|---|---|
| **Introduce Advance Shared Savings Payment** | | |
| Payments include quarterly capitated payment for CKD beneficiaries, and annual kidney transplant bonus payments—all other payments are post-reconciliation and the PY. | Offer advance shared savings payment to support infrastructure, staffing, and care delivery. | Participants face challenges with cash flow to support their infrastructure, staffing and care delivery due to reconciliation occurring ~10 months after the end of the PY.<br>The advance payment would be 20% of the FG amount and disbursed in two parts—25% would be paid at the beginning of the PY after the KCE signs the Participation Agreement, and the remaining 75% would be paid after the FG is in place. |
| **QUALITY** | | |
| **Update Depression Measure Requirements** | | |
| For PY 2024 onwards, include PHQ-9 depression survey measure as pay-for-performance. | For PY 2024, include PHQ-9 depression survey measure as pay-for-reporting and remove measure from quality methodology for PY 2025 onward. | For PY 2022 and PY 2023, data shows low index events for the PHQ-9 survey measure.<br>Having two survey measures caused considerable burden for providers and patients.<br>Measure validity concerns due to low-volume and loss of endorsement.<br>ESRD QIP captures depressing screening for ESRD patients.<br>Participants have invested heavily in the Patient Activation Measure (PAM) and found it more actionable. |
| **Update Patient Activation Measure (PAM) Requirements** | | |
| PAM survey requirement is 50%. | For PY 2025 and onward, the PAM survey requirement will be 25%. | There has been a considerable burden on providers and patients in conducting survey measures. |
| **Update Optimal Start Measure Requirements** | | |
| Optimal Start calculation includes dialysis starts and transplants before a beneficiary's alignment date. | For PY 2025 and onward, the Optimal Start measure will remove dialysis starts and transplants before a beneficiary's alignment date from the numerator and denominator. | Nephrology professionals may not be able to affect beneficiary care before the beneficiary becomes aligned. |
| **Update Optimal Start Measure Requirements** | | |
| Optimal Start Measure requirements based around the old 2728 form. | From the time of the new 2728 form change in PY 2024, update the optimal start methodology so that a patient who dialyzes with one lumen of the Central Venous Catheter (CVC) used and one needle placed in arteriovenous fistula (AVF) or arteriovenous graft (AVG) will count as an optimal start. | CMS updated the 2728 form to account for this distinction.<br>Using a mature AVG or AVF indicates the intention of an optimal start. |
| **Update Progression Measure Requirements** | | |
| The Progression Measure is Pay-for-Performance for PY 2024. | The Progression Measure will be informational for PY 2024 and will start being pay-for-performance for PY 2025. | The Progression measure is a new and complex measure which CMS is planning on delivering results based on PY 2023 data for entities to gain a greater understanding if its use and implications. |
| **HEALTH EQUITY** | | |
| **Update Health Equity Requirements** | | |
| No additional health equity requirements for PY 2025. | CMS will require a Health Equity Plan Progress update for PY 2025. | Health Equity is a priority for the KCC Model and CMS wants to see how the Health Equity Plans are progressing. |

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### Satellite Symposium

*Satellite Symposia are approved by the RPA. However, they are NOT part of the official RPA Annual Meeting as planned by the RPA Education Committee.*

### Innovating in Dialysis

Fresenius Medical Care
Friday, April 4, 2025
12:00pm–1:30pm

**Opportunities are still available – view the 2025 Exhibitor Prospectus to learn more about 2025 RPA Annual Meeting Opportunities.**

# 2024 RPA Early Career Fellows Reflect on Their Experiences

The RPA News asked 2024 RPA Leadership Development Program Fellows, Jacob Nysather and Hanna Webb, to reflect on their experiences over the past year. The RPA Leadership Development Program for Early Career Nephrologists (formerly Public Policy Fellowship for Early Career Nephrologists) is a one-year opportunity for nephrologists in practice 5 years or less, designed to help program participants develop a greater understanding of policy issues related to kidney care as well as the workings of the RPA. The new class of 2025 Fellows will be announced in the next issue of the RPA News.

## Jacob Nysather, DO

I am excited to share my experience from the Renal Physician Association (RPA) Early Career Fellowship (now the Leadership Development Program). Having recently completed the year-long program, it's been an incredibly rewarding experience that has not only enriched my professional journey but also positioned me to make a meaningful impact in the field of nephrology.

My first experience within the leadership program was the billing and coding workshop. Early on, I was introduced to the "alphabet and numerical soup" and that there are more letters than E&M or 90935. While building upon my limited business of medicine background, I was able to create a foundation of baseline understanding and gain invaluable insight into the complexities of healthcare reimbursement. By getting a comprehensive knowledge of billing and coding, I can better navigate the financial intricacies of clinical practice, which can directly influence the quality of care. Further opportunities to continue my growth occurred by attending the annual meeting and PAL (Policy Advocacy Leadership) conference. Through interactive workshops and networking with peers and established professionals, I built relationships and knowledge about current innovations and healthcare policy. Being able to engage with experts opened my eyes to the opportunity we have to shape our healthcare future.

Perhaps the most exhilarating moment was Advocacy Day on the Hill, where we had the opportunity with AAKP (American Association of Kidney Patients) to lobby Congress on behalf of kidney health initiatives. This hands-on experience underscored the importance of our advocacy efforts, as we must be adaptable in navigating the ever-changing political landscape. Meeting with legislators and their teams cemented my understanding that our voices matter and that together, we can influence policy decisions that directly affect our patients. Highlighting the value of collaboration; we are all in this together, united by a common purpose – to advocate for better access, resources, and support for kidney health.

One of the most valuable aspects of the program was the mentorship opportunities. These relationships extend beyond the program, enabling ongoing support and advice as I navigated my career. Furthermore, collaborating with fellow participants fostered a sense of community and camaraderie, encouraging open dialogue and shared learning.

As I reflect on my experience within the leadership development program, I am filled with gratitude for the opportunities I have had to learn and grow. The program has equipped me with the tools to be an effective advocate and educator for my patients and a leader within the kidney community. To my fellow nephrologists looking to enhance their leadership capabilities, broaden their knowledge base, or want to learn how to be an advocate. I wholeheartedly recommend participating in RPA and, if the opportunity arises, to partake in the leadership development program. I am inspired and committed to continuing my journey in advocating for optimal kidney care for all.

## Hanna Webb, MD, MPH

Participating in the RPA Leadership Development Program was an experience that solidified my interests in public policy and shifted my perspective and my career in a few different ways. Initially, I applied for the program because I wanted to learn about policy and become involved with a national organization. I have always felt that I could only be happy in my clinical career if I had a voice in the larger-scale, population health decisions that impacted my patients and my practice. I love being a physician, specifically knowing my patients and their needs, then having the ability to lead a clinical team in the direction that will best serve them. So, to me, this program was a natural extension of learning how to do that in the national cultural, political, and financial landscape of kidney disease, then adapting it at the local and individual practice level.

In general, the program provides early career nephrologists with an opportunity to become quickly and seamlessly involved in RPA at the highest level. This is accomplished by attending the annual meeting, board meetings, committee meetings, and Capitol Hill Day, all while developing mentorships with board members and relationships with other event attendees. Through these activities and interactions, I learned about the inner workings of the organization and how it advocates for nephrologists and pushes for progress in all spaces related to kidney disease. In addition, and even more importantly for me, I gained a deeper understanding of the forces driving decision-making in nephrology, and how these change the way we work and care for patients now and in the future. This new knowledge base is an invaluable tool in my clinical work, but also pushed me to reflect on where my own interests lie, and steps I can take in my career to be an advocate in those areas. These are lessons that few of us learn in medical training, but that provide meaning and context to our work.

There are a lot of reasons to be optimistic about the future of nephrology, and the RPA, with focus shifting toward health equity, transplant, home dialysis therapies, innovation in

*continued on page 12*

# RPA Welcomes New Class of First Look Fellows

The RPA First Look Fellowship is an opportunity for second- or third-year renal fellows to learn more about the practice of nephrology and the workings of RPA. RPA News asked the new class of First Look Fellows to share what they hope to gain from the experience.

*"I have been interested in Nephrology since medical school, drawn by the complexity of renal physiology and the unique challenges presented by kidney diseases. I'm thoroughly enjoying my fellowship, learning more about kidney diseases to provide my patients with the best care possible.*

*I feel Renal Physician Association's First Look Fellowship is a multifaceted training program that will help enhance my clinical knowledge and skills in nephrology with extensive exposure to renal diseases, including chronic kidney disease, dialysis management, acute kidney injury, and kidney transplantation. It gives access to specialized training, lectures, seminars, and workshops.*

*I also look forward to working closely with senior nephrologists and the mentor provided to me. I think mentorship is key to developing professional skills and advancing career goals. I'm excited about the opportunity to attend various committees that will give me exposure to the organizational and leadership aspects of nephrology practice, helping to prepare for roles not only in clinical care but also in policy making, medical education, and healthcare management."*

**– Ankush Asija, MD**

*"The RPA First Look Fellowship represents an extraordinary opportunity for me to align my clinical interests with a deeper understanding of the policies, challenges, and innovations surrounding kidney patients and their care. Throughout medical school, residency and fellowship I was taught the pathophysiology of many diseases as well as how to treat them but I was never taught about health equity, reimbursement and government policy related to kidney patients. I hope by completing this fellowship and getting more involved with RPA I would be able to bridge the gap between the two.*

*One of the most pressing challenges in medicine today is bridging the gap between individual patient care and broader healthcare policy and equity. The RPA First Look Fellowship offers a unique platform to learn from esteemed leaders in nephrology, delve into the nuances of legislative advocacy, and explore practice models that address disparities in kidney care. These experiences will provide invaluable insights as I enter the field of nephrology.*

*By participating in this fellowship, I hope to further develop my leadership skills and networks necessary to influence the policies and practices that impact patients and providers alike."*

**– Kevin Bogdansky, MD**

*"I took a keen interest in the Renal Physicians Association (RPA) First Look Fellowship as it presents a great opportunity to explore the intersection of clinical care, patient advocacy, and healthcare policy that we do not always get exposure to during our academic fellowship training. With chronic kidney disease and end-stage renal disease affecting millions worldwide, we as nephrologists play a pivotal role in improving quality of life, managing complex care, and addressing health disparities, and I hope to garner a greater understanding of how we can take care of our patients from a multifaceted approach.*

*I look forward to gaining insights regarding how an idea is formed to solve systems issues and how that eventually becomes a policy to enact change. I am also drawn to the RPA's commitment to fostering professional growth and leadership within the nephrology community and by participating, I aim to deepen my understanding of the intricacies of kidney care, including interdisciplinary collaboration, and strategies to navigate systemic healthcare barriers.*

***continued on page 13***

***"Early Career Column" continued from page 11***

value-based care, upstream treatments for kidney disease, targeted immunosuppressive therapies for glomerulonephritis, and technologies that improve patients' quality of life and physicians' workflow, just to name a few. Many of these advances are, for now, nephrology-specific and closely tied to federal programs and the Centers for Medicare and Medicaid Services, due to the large portion of our patients covered by Medicare and Medicaid. The need for nephrologists to be actively engaged in at least one of these focus areas is growing, but it is impossible to do alone. RPA and the Leadership Development Program, for me, offered an entry point for this, and one that I know will carry me a long way in my clinical and advocacy career.

*"RPA Welcomes New Class of First Look Fellows" continued from page 12*

*I am eager to learn from experienced nephrologists within the RPA and with their mentorship, I hope to create new long-lasting relationships, develop my skills not only in clinic practice but also within the realm of policy and advocacy."*

**– Chelsea Gertze, MD**

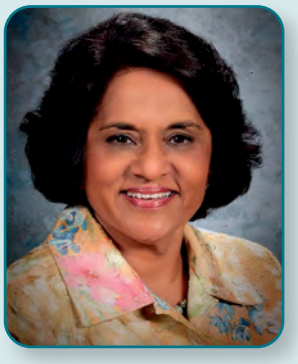
*"As a transplant nephrology fellow at Thomas Jefferson University Hospital in Philadelphia and a former physician with Valley Kidney Specialists, PC—an RPA award-winning nephrology private practice in Allentown, PA—I have had the privilege of engaging in diverse settings across nephrology. These experiences have fostered my interest in kidney care policy and in improving quality standards in transplant and nephrology care. The RPA First Look Fellowship represents an ideal opportunity to advance these goals, offering a unique platform to bridge clinical practice with policy advocacy. I am eager to deepen my understanding of kidney policy and to connect with leaders who are advancing nephrology through impactful reforms. This fellowship will enable me to contribute meaningfully to policy initiatives that prioritize transparency, accountability, and patient-centered care. Additionally, the opportunity to work with a mentor from the RPA Board of Directors is invaluable. Their insights, combined with the network of thought leaders within the fellowship, will strengthen my advocacy efforts, particularly in dialysis and kidney transplantation. I am enthusiastic about contributing to the evolution of renal care standards."*

**– Kiran Goli, MD, MBA, FASN, CPHQ**

*"Throughout my medical training I have had extensive exposure to clinical skills and patient care. Unfortunately, I have little experience with healthcare policy and regulation. Being a part of the RPA First Look Fellowship will allow me to build on my knowledge. I will use this opportunity to work with leaders in the field of nephrology and gain a better understanding of current healthcare policies and their impact on patients. This will allow me to be a better advocate for my patients. Additionally, I see a future for myself where I am involved in healthcare leadership and decision making because it will allow me to help patients on a wider scale. I am interested in learning the necessary skills to not only help individual patients, but also the entire kidney disease population.*

*In addition to policy development and implementation, I hope to continue to develop practice management skills. It is necessary for a physician to understand the business of nephrology if they want to lead a practice. Many practices are using value-based care, which is changing the reimbursement for physicians. I want to gain more knowledge on the metrics that can impact nephrology. These areas are essential for any provider to understand, and I know that being a part of the RPA First Look Fellowship will help me achieve these goals."*

**– Nolan Interial, DO, MS**



## RPA Honors and Remembers Dr. Farida Baig, MD

Dr. Baig served on the RPA Board of Directors and as Chair of the RPA Political Action Committee (PAC) Board. She was a nephrology champion and will be missed.

# A Primer on Revenue Cycle Management

Stacey Loomis

As a practice who outsources their billing operations, it is imperative to have a good relationship with the revenue cycle management (RCM) team. Knowing the metrics that need to be actively monitored should help avoid any unpleasant surprises. This can also assure the stakeholders that the practice's financial health is on track. A lot of faith is put into the RCM company. Even if a manager does not have a strong billing background, learning about a handful of key performance indicators (KPIs) can be helpful. According to the Medical Group Management Association (MGMA) and my Dashboard, here are some of those metrics that should be understood and monitored.

## Days in A/R

Days in accounts receivable (A/R) tells you how long it takes for your practice to get paid after a service is performed. It is necessary to track this because you want to have a steady cash flow from month to month. The A/R benchmark is fewer than 45 days. A higher number can be indicative of problems such as delays in signing notes, charge posting, claim submission, payment collection or posting. Review how effectively your RCM company is handling these steps and address bottlenecks, especially if the delays are on the practice side.

## Denials

Denials refer to whatever prevents a practice for being paid for their claims. Monitoring claim denial rates is essential for nephrology practices, because of the complexity of coding and billing requirements by the payors. The denial benchmark is 5-10%. Higher denial rates can be a red flag, indicating potential issues with coding, eligibility verification, provider credentialing, or accurate claim submission. Work with your RCM company to assess the trends and develop action plans to prevent them whenever possible.

## Clean claim rate

Clean claim rate reflects the percentage of claims that are submitted and paid without the need for corrections. A high clean claim rate is a sign of effective coding, thorough eligibility checks, and adherence to payer guidelines. The clean claim benchmark is 90-95%. Ask for a breakdown from your RCM team of clean claims versus those that need to be reworked. Accurate coding and staff training are effective in keeping these numbers where they should be.

## Net collection percentage

Net collection percentage serves as a key indicator of revenue cycle efficiency, reflecting the amount collected compared to the actual charges for a given service, after adjustments or write-offs. Efforts should focus on collecting from secondary and tertiary payors, not just the low hanging fruit. A lot of Several factors influence this metric, including fee schedules, payor contracts, and geographic location. The benchmark for net collection is 95–99%. If your net collection rate falls below this range or is lower than expected, consult with your RCM provider to identify the root cause. Potential issues may include underpayments, contractual misalignments, or gaps in patient collections—all of which should be promptly addressed.

## Patient payment collection

The ability to effectively collect money due from patients will become even more important as deductibles and co-insurance amounts continue to increase. It is essential that your office staff as well as your RCM company have a good comfort level with what can be a delicate task. Good scripts and workflows are essential for this. Review patient payment plans, collection timelines, and processes to ensure your RCM partner is actively engaging patients and providing options to facilitate payments to your practice.

## Charges and payments

It is crucial to know your charges and payments for any given month. However, it is equally important to understand these numbers in greater detail—broken down by provider, location, payor, and service line—and to track them over time. While a snapshot of performance at a specific point is helpful, the ability to compare data with prior months, years, or similar practices can provide invaluable insights. Familiarizing yourself with this information allows you to identify concerning trends and collaborate with your RCM team to investigate the causes and implement solutions to enhance your practice's performance.

## Coding utilization

The tracking of CPT coding utilization is essential for nephrology practices to ensure accurate billing and to optimize revenue cycle management, and to maintain compliance with regulatory standards. By closely monitoring the usage of CPT codes, practices can identify patterns in services rendered, address discrepancies, and avoid the kinds of errors that could lead to denied claims or audits. Under coding is just as inaccurate as over coding. Correct coding is especially important in nephrology, where services often involve complex procedures like dialysis management, chronic care coordination, and vascular access monitoring. Proper coding and documentation procedures not only support financial sustainability but also uphold compliance with regulatory agencies. Additionally, accurate coding and documentation fosters better communication between providers and payers.

## Payment posting

Payment posting is a critical component of revenue cycle management for a nephrology practice, as it directly impacts cash flow. Effective payment posting ensures that payments

*continued on page 15*

*Stacey Loomis has served as the practice manager for Midwest Nephrology Associates in St. Peters, MO since 2006. She is a member of the RPA Practice Managers and Education Committees.*

# Contracting Around AI in Healthcare: Navigating the Inevitable

Jake Cilek

Nicholas Adamson

Over the past year, artificial intelligence ("AI") has grown increasingly popular as it has captured significant media attention, invoked huge amounts of private investment, and drawn newly found regulatory scrutiny. While AI remains mostly conceptual in implementation across many industries, one industry where the rollout has been swift is healthcare. Most practitioners and healthcare systems are already engaging with AI tools, whether they aware of this engagement or not. This article will overview how AI is being used currently, what liability concerns providers and healthcare entities should consider, and lay out some best practice tips when dealing with AI.

## Defining AI and AI's Use in Healthcare

### What is AI?

In discussing how AI is used in healthcare, it is first worth acknowledging the breadth of concepts included in the current usage of the term "AI." Like many new concepts that garner significant private investment and corporate interest, AI has become a buzzword encompassing a huge amount of different ideas.

At its core, AI refers to something that is capable of machine learning, or in other words, teaching itself and evolving over time, eventually learning from itself instead of requiring additional human inputs. However, the AI that is currently in the marketplace is instead better thought of predictive learning technology, which are tools that can predict the correct outcomes based on reviewing data sets.

As such, most AI that is currently available requires the submission of a huge amount of data. This data is then used to "train" the AI, which allows the AI to better predict the outcome of future data it is given. As an example, imaging scan AI technology, which reviews clinical scans to detect issues, uses patterns it learns from reviewing enormous amounts of clinical scans and their findings to better predict how a new scan should be read. Under this structure the outcome produced by AI is necessarily only as good as the data inputs allow.

### AI's Current Implementation in Healthcare

In general terms AI's usage in healthcare can be divided into two broad categories: clinical implementation and non-clinical implementation. Both of these implementations currently follow the predictive learning models discussed above. However, the two categories vary greatly in terms of how much risk a party is taking on in using the technology.

### Clinical Uses of AI

Clinical uses of AI involve, as one would assume, anything where AI is being used in a clinical context. Some of these uses could be explicitly tied to a specific billing code,[1] or they could

*continued on page 16*

*Jake Cilek is a Partner at Benesch Healthcare +.*
*Nicholas Adamson is an Associate at Benesch Healthcare +.*

1 Some states have begun rolling out billing codes specific to the usage of certain AI technologies.

*"Practice Management" continued from page 14*

from insurance companies and patients are accurately applied to the appropriate accounts, reducing the risk of errors that can lead to billing disputes or delayed collections. Best practices for nephrology practices include implementing automated systems to streamline the posting process, reconciling deposits daily to avoid discrepancies, and conducting routine audits to identify and correct underpayments or misapplied funds. Maintaining detailed records and promptly addressing payment variances are essential for maximizing revenue and ensuring that the practice remains financially stable while providing high-quality patient care.

Does your practice have any service lines with vendors, such as remote patient monitoring? If so, consider having that collection detail in a prominent place on your dashboard showing at least several months of activity. This will help you easily spot troubling dips in collections related to this service line, which can be costly.

Transparency and communication with your RCM company are necessary for ensuring the financial health and operational efficiency of a medical practice. Honest and open communication fosters a collaborative partnership where both the practice and the RCM team should be aligned on goals, expectations, and processes. Transparency allows the practice to understand how their claims are being managed, why certain denials or delays occur, and what steps are being taken to resolve them. Regular updates, detailed reporting, and real-time access to performance metrics enable the practice to monitor key revenue cycle indicators such as claims acceptance rates, payment timelines, and accounts receivable trends. Clear communication also helps address potential issues before they escalate. A respectful and transparent relationship builds trust, ensures accountability, and enhances the practice's ability to focus on providing care to our patients.

*"Legal Column" continued from page 15*

merely assist with various clinical tasks. Below are a few types of clinical AI that are already in the marketplace:

- Scan reading technologies;
- Lab reading technologies;
- Drug trial administration;
- Performing initial risk assessments; and
- Technologies assisting with developing patient care plans.

### Non-Clinical Uses of AI

Non-clinical AI includes any use of AI that does not directly interact with the patient's care. These uses of AI technology often involve performing administrative or financial tasks. Below are a few types of non-clinical AI that are currently in the marketplace:

- Predictive language clinical note taking;
- Patient visit write-ups;
- Billing submission technologies; and
- Patient independent research technologies.

## Tips for Navigating and Contracting with AI

AI carries a host of novel concerns for healthcare providers to be aware of, which vary based on the kind of AI being implemented. For clinical AI, the government is more likely to take a very hands-on regulatory approach quickly given the financial overlay of healthcare spending and the direct effect on patient wellbeing. As such, clinical AI implementation carries more inherent risk compared to non-clinical uses, but this is not to say that non-clinical AI is a risk-free undertaking. Non-clinical AI can directly impact, most directly, how bills are submitted to payors, how subsequent clinical activities are handled, and other financial and performance-based care outcomes. These uses can open a provider up to liability in the form of false claims act cases, inadvertent referrals, and future malpractice issues, for example.

It is worth noting that it has not yet been determined with certainty who within a given arrangement involving the use of AI will bear any attendant liability as between the provider and the AI technology vendor. For example, if a nephrologist uses AI software in connection with completing a patient's risk assessment and determining a course of treatment, and that assessment and course of action proves to be wrong, who will ultimately be responsible here? Courts could determine that the AI technology vendor is to blame for creating a tool that was unreliable, or courts could determine that the provider bears the liability for using an unreliable product. We are also likely to see medical boards and payors around the country weigh in with respect to scope of care and medical necessity concerns, respectively, which could shift the pendulum back to the provider in terms of bearing risk for unreliable or misused AI solutions.

Ultimately most observers expect that courts are likely to find that both providers and AI technology vendors bear some risk if AI is not used properly. Courts will likely, at a minimum, find that AI technology vendors have the duty to market their products honestly and not promise results beyond the reach of the AI technology itself.[2] However, providers will likely ultimately be liable for any uses of AI that decrease patient wellbeing, which again could be driven at the state regulatory level through applicable licensing and accreditation agencies. To that end, this risk for providers is likely heightened when dealing with clinical AI technologies as providers always bear ultimate responsibility over clinical proceedings.

Below are five tips that providers and healthcare entities can begin implementing now to safeguard against the coming risks with AI technologies:

1. **Take a hands-on approach with vendors to ensure you understand the products you use.** As AI becomes increasingly prevalent across the marketplace, it will become harder to determine who is using AI and who isn't. As a result, providers and healthcare entities must understand whether their various partners and vendors are using AI technologies to perform their various functions. For example, numerous telehealth companies are rolling out AI technology offerings within their normal telehealth platforms and it is very easy for providers using those platforms to begin using this new AI technology without fully realizing what they are interacting with. As a result, providers should take a more active role in reviewing what technologies their various vendors and partners are using or build out contractual language requiring disclosure of any usage of AI products.
2. **Ensure that any clinical uses of AI always have a layer of provider oversight.** As discussed above, clinical uses of AI carry increased regulatory risk as the government is always more inclined to scrutinize decisions that directly impact patient wellbeing. While many of the guardrails for using clinical AI will likely be determined in future lawsuits and statutory schemes, for now providers need to ensure that there is always a layer of human review when using AI. If an AI tool is helping to read a lab, for example, a provider should ensure that the AI tool's findings line up with the provider's understanding and any review by a human provider should be well documented. Courts, regulatory bodies, and payors are almost certainly not going to look favorably upon any use of AI in a clinical setting which is not overseen by human providers licensed to conduct those services.
3. **Review data privacy policies and create custom procedures for AI technologies.** One unique concern associated with using any AI technology in the healthcare space relates to data privacy. As discussed above, AI uses data inputs to train itself to better perform in the future.

*continued on page 17*

2 The Texas AG recently brought its first case against a healthcare AI technology vendor related to false marketing. The AI technology itself was marketed to be more accurate than it turned out to be in reality. Because a settlement was quickly reached here, it is unclear how the government viewed the provider's role in implementing these technologies. *See* Texas Attorney General, *Attorney General Ken Paxton Reaches Settlement in First-of-its-Kind Healthcare Generative AI Investigation* (Sept. 18, 2024), https://www.texasattorneygeneral.gov/news/releases/attorney-general-ken-paxton-reaches-settlement-first-its-kind-healthcare-generative-ai-investigation.

# G2211, Home Dialysis for AKI

**Question:** I heard that there were some changes to the G2211 code that can be attached to E&M claims for complex patients that our practice has been seeing on a long-term basis. What are the changes, and can we still bill the services like we did in 2024?

**Answer:** To answer the second question first, yes, nephrology practices can still use the G2211 complexity modifier add-on code for complex patients with whom the practice has a longitudinal relationship. The changes CMS made for 2025 were to remove some of the restrictions associated with claims also using modifier -25 to indicate that a separate evaluation-and-management (E&M) service was performed on the same day as another procedure or service. Specifically, CMS now will allow payment for G2211 when billed with an annual wellness visit (AWV), vaccine administration, or any Medicare Part B preventive service in office/outpatient settings starting in 2025. Thus, the Agency expanded the opportunities in which G2211 can be utilized for 2025.

**Question:** It is my understanding that starting in 2025, CMS will cover home dialysis for patients with acute kidney injury (AKI)—how should nephrologists bill for their care of these patients?

**Answer:** RPA believes that the most likely scenarios are that the nephrologist will bill for their services using E&M codes for patients seen in their offices or by telehealth if the patient is in their home (in this case using CPT codes 99213, -14, or -15). Alternatively, if the patient happens to be seen in the dialysis facility, the most appropriate code to use would likely be CPT code 90945. What is usually known as the inpatient dialysis code family, (CPT codes 90935, -37, -45, and -47) are not on the approved telehealth list and thus cannot be used if the patient is in their home.

**Question:** I bill the monthly capitation charge for our patients. But we also have transient patients that come to the clinics for a couple of treatments when they are in the area. For these transient patients, what are we allowed to bill? Say the patient comes for one visit, our doctor does not see them, but they are still considered under our care. I have been billing CPT code 90970 for the dates of service they were under our care. For example, the patient gets treatment on 10/3/2024 and 10/5/24. I would bill 90970 for DOS 10/3/2024 through 10/5/2024; are these all the dates I would bill for? I guess where I am getting confused is when does the patient stop being under our care? The next date of treatment they receive is in their home clinic. I want to bill as accurately as I can, and at the same time, want our doctors to be reimbursed for what they should be reimbursed for.

*"Legal Column" continued from page 16*

However, in the healthcare space this training can create huge privacy issues. For example, if two nephrology practices use the same AI clinical note taking tool, and that tool is training based on clinical notes that the two practices input, then there is a huge risk of the underlying clinical notes being shared between the practices. Such data may be buried within the AI programming itself but there is always risk of it being extrapolated in the future. As a result, providers will need custom BAAs and novel contractual language that limits how their PHI and other sensitive data can be used to train AI technology to ensure it PHI and other data is not shared with others.

4. **Create comprehensive policies and procedures discussing the use of AI technologies.** Another good safeguard that practices can exercise right now is creating policies and procedures addressing the use of AI. This serves a few functions for a provider. Firstly, it insulates providers somewhat from a situation where a given employee is using AI in a way that the provider would not deem appropriate. Secondly, it demonstrates a degree of diligence and awareness relating to the dangers of AI usage that would look favorable in the event of any future court proceedings. And lastly, it ensures that someone from the provider's office is tracking the rollout of these technologies to determine what implementation makes sense for the provider.
5. **Exercise, and document, diligence in connection with rolling out any new uses of AI.** Providers and healthcare entities should document diligence with regards to using any AI technologies. In the event that any problems arise relating to using a given AI technology, governmental entities will look to see how those providers implemented the technologies. Providers can protect themselves by documenting slow roll outs where results are intermediately monitored by providers before beginning a full implementation. For example, if a healthcare system wants to roll out AI dictation for clinical notes, being able to document a slow roll out where select providers are evaluating the results of the AI usage over time before full system implementation shows diligence on behalf of the provider which will look favorable to courts evaluating whether those providers acted in accordance with their necessary standards of care.

While there are plenty of risks associated with using AI in healthcare, but this does not mean it should be avoided altogether. As a matter of fact, the use of AI could eventually be required in some situations if the standard of care eventually shifts as a result of especially helpful or accurate AI tools. As such, providers and healthcare entities should not reject the overall usage of AI, but should be cognizant of the risks AI carries and diligent in how they interact with AI technologies.

***Editor's Note:*** *This article is for information purposes only and not for the purpose of providing legal advice. You should contact your attorney and/or tax advisor to obtain advice with respect to any particular issue or problem. The opinions expressed in or through this article are the opinions of the individual authors and may not reflect the opinions of Benesch Friedlander Coplan & Aronoff LLP or any other individual attorney.*

**Answer:** In this scenario you should bill the daily MCP code (90970) for all of the days the patient was under your care (i.e., your practice is the one getting the call if the patient needs urgent help), so if they arrive in your area on say 10/1 and are there for 14 days, leaving 10/15, you can bill 14 counts of 90970, which would pay roughly half of the month's MCP payment amount (90970 pays 1/30th of the local MCP amount). There's not a specific physician presence requirement per se, although RPA strongly urges nephrologists to see patients under their care monthly at least, weekly ideally—so it's not based on how often the doc/AP sees the patient, it's based on the number of days your practice is accepting medico-legal responsibility for the patient. Presumably, they stop being under your care the day they go home, when you're no longer getting the call if the patient has an issue.

**Question:** I also have a question about NP billing–Does the doctor have to always cosign the notes for on the NP? Can you clarify for me?

**Answer:** In most states, physicians generally aren't required to co-sign nurse practitioner (NP) notes unless mandated by specific state laws, practice policies, or certain insurance guidelines. NPs typically practice with a significant degree of independence, and a physician's co-signature is not usually needed unless it's outlined in their collaborative agreement or is a requirement set by the practice or payer.

For example, Medicare generally does not require physician co-signatures on NP notes; however, some commercial payers may have different rules. In certain situations, such as complex cases or when specific state regulations apply, co-signing may be necessary. It's always best to review both the payer requirements and the practice's internal policies to ensure full compliance.

**Question:** My practice has begun to provide home dialysis training services on a more regular basis, and I want to make sure our nephrologists are documenting the services appropriately. Can you provide some guidance on how to do so?

**Answer:** First, it is worth noting that this is an instance where CMS has in our view wisely chosen not to specify what is required for appropriate documentation for CPT codes 90989—dialysis training, completed course, and CPT code 90993—dialysis training, course not completed (per session), and instead allows the nephrologist and allied practitioners to determine what is appropriate to note in the patient record.

As for what should happen and be documented, the service should be provided in place of service 65 (ESRD Treatment Facility, certified by Medicare), and we recommend that the date of service be when the date when the course is completed. Additionally, RPA recommends that the practitioner document their presence at the training and participation in some aspect of the training. One other note: the home dialysis training codes are not included on the list of Medicare codes approved for telehealth, so home dialysis training services cannot be performed via telehealth, at least under Medicare.

In the September 2022 Coding Corner column RPA suggested the following text as an example of how to document home dialysis training services:

> *"On (insert date/dates), I participated in the home dialysis training for (patient name) in peritoneal dialysis as CAPD (or automated PD utilizing the XXX system) or home hemodialysis utilizing the (XXX) system. I witnessed the patient perform the dialysis procedure. The patient exhibited an understanding of the process, was successful in completing the procedure, and was advised about potential complications and how to respond."*

It is important to note that this is only suggested language for what might be addressed in documentation for home dialysis training, and of course notes for specific nephrologist-patient encounters should accurately reflect the activities and interactions that occurred in that visit.

***Editor's Note:*** *RPA consciously takes a conservative position when providing coding and billing advice to its members since the possible unintended consequence of taking a less conservative approach could be a claims audit with the potential of doing tremendous harm to an RPA member's practice. This column has been designed as a general information resource. It is not intended to replace legal advice. The responses to the questions submitted to the Coding Corner column have not been vetted by attorneys, and attorneys have not been consulted in the drafting of any of the replies.*

# November/December

- On November 1, CMS released the 2025 ESRD Prospective Payment System (PPS) final rule and fact sheet. It finalized a 2025 base rate of $273.82, an approximate 2.7% increase from the CY 2024 ESRD PPS base rate of $271.02. The final rule also maintained the policy proposed in the summer to allow home dialysis care to be provided to acute kidney injury (AKI) patients.

- On November 15, RPA and the house of organized medicine urged Congress to enact H.R. 10073, the Medicare Patient Access and Practice Stabilization Act of 2024. This bipartisan legislation would replace the currently scheduled 2.83% payment cut for 2025 with a 1.8% payment update, which is equivalent to 50% of the Medicare Economic Index (MEI) projected for 2025. RPA's grassroots alert on this manner has generated over 500 messages sent to members of Congress in support of H.R. 10073.

- In mid-November, the AMA House of Delegates adopted a resolution submitted by RPA and presented by RPA Delegate Dr. Rebecca Schmidt through which it will become official AMA policy to: (1) advocate for Medicare coverage of non-emergent medical transportation specifically for patients requiring dialysis treatment; and (2) partner with Center for Medicare and Medicaid Services (CMS) to develop policies to ensure financial assistance for non-emergent medical transportation for dialysis treatments and to transplant centers for kidney transplant evaluation and related care for Medicare beneficiaries.

- On November 22, RPA and a coalition of medical organizations committed to value-based care urged Congress to include an extension of Medicare's Advanced Alternative Payment Model (AAPM) incentive payments in any year-end health care package that is enacted. The letter highlights that several models accrued $2.8 billion in net savings for the Medicare program in 2023, while improving patient access and quality, and called on lawmakers to "prioritize addressing these critical physician payment issues during the lame duck session to ensure that physicians have the resources needed to support beneficiaries' continued access to high quality, patient-centered care." Extension of the AAPM incentive payments was an RPA legislative priority for 2024.

- On December 4, RPA and a broad array of physician specialties and health care groups urged Congress to enact the bipartisan **Dr. Lorna Breen Health Care Provider Protection Reauthorization Act (H.R.7153/S.3679)**. This legislation is the is the first and only federal law dedicated to preventing suicide and reducing occupational burnout, mental health conditions, and stress for health care professionals. The letter calls for the program's reauthorization prior to the close of the 118th Congress, either as a stand-alone measure or as part of any legislative package.

## RPA RECOGNIZES CORPORATE PATRONS

The RPA Corporate Patrons Program is designed to augment the alliance between stakeholder industries and the RPA since corporate members of the nephrology community play an important role in optimizing patient outcomes. Gifts from corporate patrons are for scientific or educational purposes. During the year, RPA leaders meet with representatives from corporate patrons participating companies to discuss areas of mutual concern and interest. This informal dialogue benefits industry and the association. Potential donors should contact the RPA office to obtain additional information. Links to all of our corporate patrons' sites may be found at www.renalmd.org.

RPA is pleased to acknowledge the support provided by all of our corporate patrons in this issue of RPA News.

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Gary G. Singer, MD
RPA President-Elect
Midwest Nephrology
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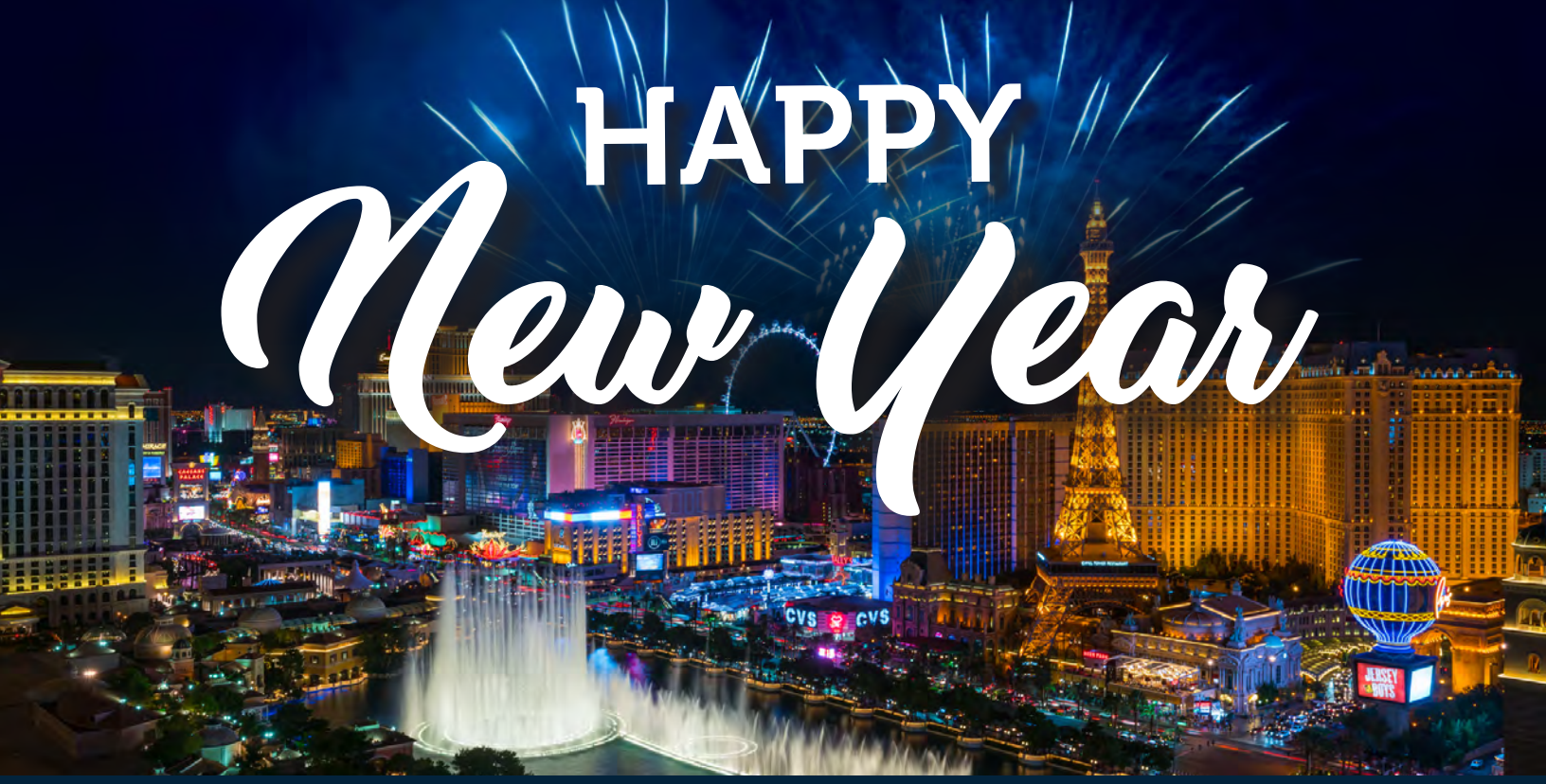


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